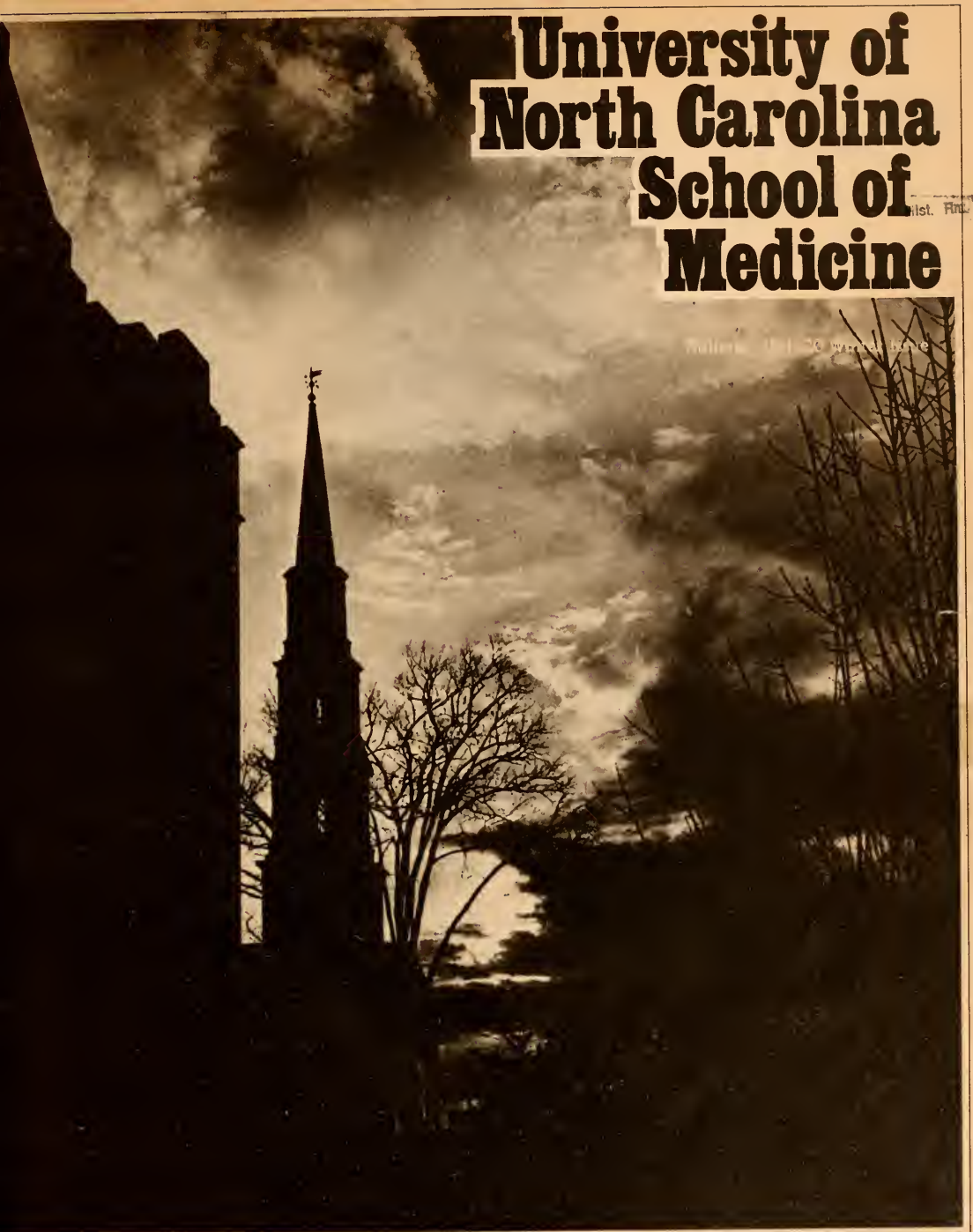
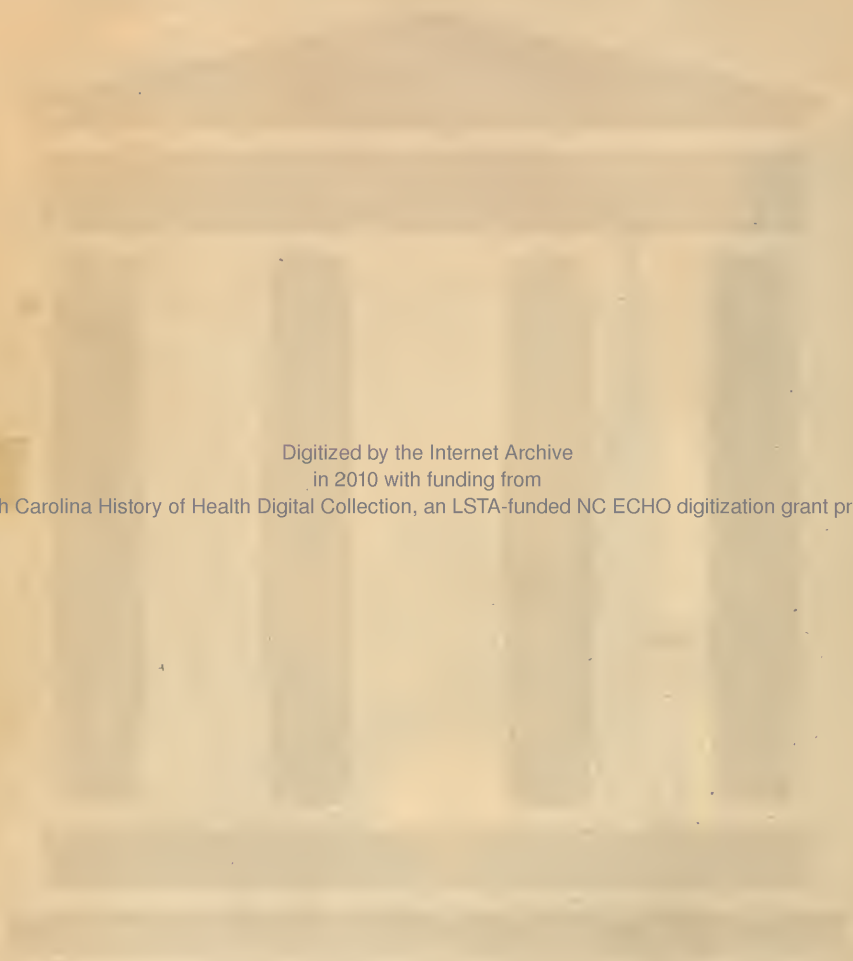


University of North Carolina School of Medicine





Digitized by the Internet Archive
in 2010 with funding from
North Carolina History of Health Digital Collection, an LSTA-funded NC ECHO digitization grant project

Like The Chapel Hill Virus, The Bulletin mutates regularly.

But, we hope, with happier results.

This year, The Bulletin will be published quarterly in a new format.

We think it is the best way to meet the needs of an institution which is growing constantly. The magazine, which Miss Maria Leon has been editing on her own time for the last several years, would now be too costly if continued. Paper costs are skyrocketing and postal hikes are anticipated.

That, and the fact that we have so much news, led the Editorial Board to conclude that a newspaper was best for us. At the outset, it is only honest to tell you that no publication with advance deadlines can accurately reflect — up to the minute — what is going on here. We have a number of programs (the Area Health Education Centers, for example) which change daily. But, we'll do our best.

We hope you like the new Bulletin. Each member of the Editorial Board was chosen for his special interest in the publication. While we agreed that nothing creative was ever concocted in committee meetings, we have spent months talking among ourselves about what we wanted The Bulletin to do. We have pored over publications from medical schools all over the country, and we have tracked down people who had ideas to offer.

The most important ideas and news though, comes from the readers. There's a form on the book page for your news and ideas. Rip it off, fill it in and let us hear from you.



Bulletin Advisory Board

William Blythe, M.D.
John Herion, M.D.
John Sessions, M.D.
Raymond Wheeler, M.D.
Nathan Womack, M.D.
Oscar Sapp, III, M.D.

Chairman, Ex-Officio Member

Cheree C. Briggs, Editor

Credits

Photographs by Maury Taggart
Design. Gibbs Associates, Inc.

Bulletin: Vol. 20 Winter Issue

University of North Carolina School of Medicine

Table of Contents

N.C. towns: happy hunting grounds for new M.D.'s	4
It's you, not your father, who's applying	6
Of chalk, classrooms, and clinics	7
Belgium births & loud Moslem prayers	8
Breaking Out	12
126 MacNider	15
Graduation 1973	16
Who's where	19
I don't want to tell you what to do, But.	22

The Bulletin, of which this publication is Volume 20, No. 1, is published quarterly by the UNC Medical Alumni Association, Chapel Hill, N.C., 27514. Postage is paid by the non-profit association through U.S. Postal Permit No. 24.

N.C. towns:

happy hunting grounds for new M.D's.



A pilot program, designed to learn how the UNC School of Medicine can help North Carolina towns find doctors, is believed to be the first of its kind in the United States.

A spokesman for the Association of American Medical Colleges in Washington, said he knew of no recruitment effort similar to the one at UNC.

School officials are using a personal, direct-mail campaign to identify candidates for communities to recruit. To date, 391 of the 3,800 young doctors in mid-Atlantic and southeastern hospitals contacted said they will consider seriously practicing in North Carolina. (These are first, second and third year residents. Some will be ready to practice in June, others between 1975 and 1977).

John Payne, associate director of the Division of Education and Research in Community Medical Care, said, "Many communities have said all they wanted was a chance — just a chance — to talk to prospects. We want to give them as many candidates as possible. The 13 communities from which we have had specific requests will do the actual recruiting, but we think the communities can sell themselves if the School of Medicine helps them along a little."

The cooperative campaign works this way: last July, Payne wrote the administrators of hospitals having internship and residency programs approved by the American

Medical Association and asked for the names of those in their programs. In December, the first phase of the mailing was completed when doctors from Baltimore to Miami, and as far west as Arkansas, got the packet prepared by the School's staff.

It contains a personal letter; a reply card; a state map; a copy of the colorful brochure used by the N.C. Department of Travel and Promotion, "The Goodliest Land," and a booklet featuring five North Carolina doctors who tell, in their own words, why they like practicing here. They represent a cross-section of the state, from rural to urban.

While the specialties and geographical preferences of the 391 from the first mailing were being matched with the needs of communities, a second mailing was prepared for 750 residents in North Carolina hospitals and another 300 at Grady Hospital in Atlanta. Grady is the teaching hospital of Emory University School of Medicine.

Since the School is only part of the recruitment program, Payne was asked to explain what communities wanting physicians were doing. Payne said they had asked administrators in University-affiliated hospitals and the directors of the six Area Health Education Centers to survey the needs of the counties they serve and reply as soon as possible. In addition, some doctors have called the School directly and they, too, have been sent names of prospects.

Payne said that local administrators and doctors "were very cooperative" and many want to call

candidates themselves. Payne said that their support would make the program successful, because "we don't have money to pay travel expenses. All we can offer is the opportunity to talk to a doctor who has declared an interest in us." At the same time the community representatives receive the candidates' names, the candidates will be told which towns will have doctors who may be calling them.

The first phase, Payne said, "exceeded our expectations." In addition to the 391 prospects, six residents now out of North Carolina said they already planned to return. The remaining 51 who sent regrets offered interesting comments. One volunteered, "If I ever leave Birmingham, it'll be for North Carolina." Quite a number offered encouragement and thanked the school and the state for the invitation. One doctor with both feet planted firmly in Arkansas sent thanks and an assurance that, "North Carolina is a great place for vacations." In one sense, staffers say that the fact 447 harried residents took time to fill out a card is positive even though some had already made plans to practice elsewhere. One goal of the pilot program is to learn as much as possible about what prompts residents to choose places to practice.

The replies came from 52 hospitals. Of these, seven hospitals had more than 20 residents who said they were interested. They are: Jackson Memorial Hospital, Miami, 43; Medical College of Virginia, 39; City of Memphis Hospitals, 36;

University of Florida at Gainesville, 32; the University of Virginia, 26; the Medical College of South Carolina at Charleston, 26; and Johns Hopkins University at Baltimore, 22.

Of the 391 candidates, 225 were in one of six specialties. Family practice residencies are still new but 24 family practice residents are interested. There were 89 in internal medicine, and 36 from persons in obstetrics and gynecology. Pediatrics drew 27 candidates. These four represent the "primary care" specialties. In addition, surgery residents sent in 46 replies and 23 psychiatry residents said they wanted to know more about the state's mental health care system.

Payne said the school considers finding primary physicians one of the main purposes of the program, but he said almost all specialties are represented. "If some town wants an ophthalmologist, we have them. We picked up one dentist somehow in our first mailing," he said.

Many prospects asked specific questions about doctor-patient ratios in general and by specialty, and others wanted detailed information on licensing procedures. This information is being sent now.

Payne said, "A number of things combine to help us think we have some serious prospects here. But we must remember prospects."



Meet Miss October, who in real life is Mrs. Betty Neilson, the Executive Secretary for the UNC Medical Alumni Office. She was wounded in action last October frantically preparing for Medical Parents Day. The officials at N.C. Memorial Hospital thoughtfully put her in a room on 3 West, where her friends sneaked in so she could cheer them up. That's right, she cheered us up while recuperating. As soon as she could "crip," she hobbled back to work dispensing coffee to any alumnus, cheerful smiles to everybody and lots of mail for the postman. She has learned to "love" her cast, she says, and hopes to have it off by Valentine's Day. At that time, unless she is given an ankle transplant, she says she will not pose as Miss February. "While they were at it, they could have built me a beautiful new leg," she said.

"It's you, not your father, who's

A staff member comes into 226 MacNider. Before the glass door can swing shut, an anxious student pops up, sticks out his hand and identifies himself. He is clearly embarrassed when he learns he has not greeted a member of the Admissions Committee, and he quickly sits down again.

Few who come for interviews are so painfully nervous, but none of them is casual. Even though the odds are heavily stacked in favor of North Carolinians (no more than 15 per cent of any class can be from out-of-state, and it is rare that the percentage is that high), Phi Beta Kappas and Morehead Scholars have been known to be rejected. The competition gets stiffer every year, and the students' apprehension increases. National trends in medical education and funding aggravate the apprehension further.

Students know that many U.S. medical colleges — suffering from cuts in federal funds — will do well to maintain the size of the classes they now have, although Carolina plans to expand its current enrollment of 471 students to 650 students by 1979. They also know that, just as the number of medical school applicants is increasing, the number of professional options are decreasing. For example, a student who should be counseled to pursue a PhD. rather than an M.D. often feels that federal cut-backs in research make this a risky course. PhD.'s in research are needed, but there is not going to be money to pay them unless current predictions are wrong.

Legislators, angry parents and frustrated students often ask, in exasperation, "How does a student get in the School of Medicine?"

The answer is simple in the sense that only the student and his

record can get him admitted. Pressure does not work, as one student learned. He called and asked, "Do you know who my father is?"

Mrs. Louise Rhodes, secretary to the Committee, replied that, indeed, the committee did know his father, an excellent clinician. But, she reminded him, "It's you, not your father, who is applying."

The fact is that not even the Honorable James Holshouser or the Dean, Christopher C. Fordham, III, M.D. can get a student admitted. Dr. Fordham, who served as chairman of the committee before he became dean continues to support the policy of keeping the Admissions Committee autonomous.

Dr. William Bakewell, Professor of Psychiatry and Chairman of the Admissions Committee, has served on admissions committees at two other medical schools.

"In my experience, admission committee decisions are not influenced by an applicant's 'pull.' That kind of pressure just doesn't work. Usually the student himself knows nothing about such efforts to sway the committee and would be embarrassed if he did. I think most students want to be considered on their own merit!"

Dr. Bakewell described five factors that are used by the committee to evaluate applicants: the student's grades, the Medical College Admissions Test scores, the candidate's extra-curricular activities, letters of recommendation and the impressions gained during personal interviews.

Dr. Bakewell said that the current applicants' credentials are so impressive that, "Many of us who were admitted to medical schools in past years wouldn't be strongly competitive by today's standards."

"We are seeing very gifted

young people with outstanding records, high admissions test scores and a fantastic array of non-academic interests and achievements. We have an embarrassment of riches."

Each applicant who is considered competitive academically, and comes well recommended by his professors, is seen for two 30 minute personal interviews. One is with a faculty and one with a student member of the committee, he said.

A quick look at the statistics tells part of the story. In 1972, when the committee was considering candidates for the Class of 1973, there were 1,578 applications for 110 slots, and 1,032 of these were from out-of-state students. The committee is making an effort to discourage indiscriminate applications from non-residents who have no particular interest in making North Carolina their home.

"We are making stronger statements about the requirements both to pre-medical advisors and out-of-state students," said Dr. William Straughn, Professor of Bacteriology and Director of Admissions.

"We are seeing a decrease in the number of out-of-state applications, which we consider significant. We tell them that they need a 3.5 academic average, high MCAT's and must evidence a strong desire to go here to school."

No rigid standards are applied to applicants, however. Class averages for academic averages and MCAT's are available but each application is considered individually. No one factor is the "key" to admission.

As stated, applications for the Class of 1973 numbered 1,578. After first review, 598 were invited for interviews and letters of recommendation for these students were

applying.”

requested. Forty-two students were eliminated in the interviewing process, leaving 546 students competing for the 110 places.

The class roster for 1973 includes 10 out-of-state students. There are 23 females in the class, six of whom are black. There are 77 males, seven of whom are black.

The last stage of application is surely the worst — waiting for the word. The process of application to medical schools is almost a career for some, who apply to as many as a dozen schools. It is believed that most students usually apply to six or seven schools. The first letters of acceptance start going out January 15, 1974, and Mrs. Rhodes' office is haunted by candidates who want to know where they stand.

“We are honest with them, and let them know what their chances are. Naturally, every student whom we accept is not going to come here, so there is a little leeway. But we think they deserve to know the truth. It isn't easy telling them.”



Of chalk, classrooms, and clinics

George Johnson, Jr., '50, has been named the first Roscoe B. Gray Cowper Distinguished Professor in Surgery. Dr. Johnson is Professor and Chief of the Division of Vascular and Traumatic Surgery at the UNC School of Medicine.

Dr. Cowper, a native of North Carolina and a member of the Class of 1930, practices in Big Spring, Texas. He has been practicing for 39 years, and since 1940, directed the work in the Cowper Clinic and Hospital. At one time, there were five physicians in the group, but now there are two. However, Dr. Cowper says that the older he gets, “the harder I work.”

Dr. Johnson has served as a member and advisor to various committees at the state level which have worked on developing better emergency medical services. He is a member of a number of professional societies, and has more than four dozen publications to his credit. Dr. Johnson served as President of the Durham-Orange County Medical Society in 1971 and he is a member of the Executive Council for the University Association for Emergency Medical Services. After completing his work at UNC, Dr. Johnson graduated from the Cornell University School of Medicine. He completed his internship and residency training at New York Hospital. Dr. Johnson joined the faculty in 1958 as an instructor. He was made a Professor of Surgery in 1969.

James A. Bryan II, Professor of Medicine, won the Central Carolina Bank's Excellence in Teaching Award. The bank established the \$1,000 prize last spring, with the recipient to be selected by the students.

James W. Woods, Professor of Medicine, was awarded the Silver Medallion, the N.C. Heart Association's Highest Award. He was honored “for distinguished service” at the association's 24th annual meeting. He has been active in the association since 1955, and served as its president in 1971.

Kenneth M. Brinkhaus has been elected President of the American Association of Pathologists and Bacteriologists. Dr. Brinkhaus is a Professor of Pathology.

K. Kenney Gray, Assistant Professor of Medicine and Paracology, has been named the 1973 Jefferson-Pilot Fellow in Academic Medicine. The fellowship provides \$2,000 a year for four years to support scholarly and investigative activities. He will be studying the effects of hormones on the intestinal absorption of calcium or phosphorus.

New departmental chairmen have been named. They are: Thomas E. Curtis, Psychiatry; Robert G. Crounse, Medical Allied Health Professions; W. W. McLendon, Hospital Laboratories and Joseph Grisham, Pathology.

Carl Gottshalk has been named to the National Academy of Science, Institute of Medicine.

Floyd Denny, Chairman of the Department of Pediatrics, is now an Alumni Distinguished Professor. He was named by the University last spring.

Belgium births & loud Moslem prayers

by Pat Mullen '74

I came to medical school in a round-about way. In 1968-69 I spent a year in Montpellier, France in the Junior Year Abroad program of Davidson College. Through a set of experiences and contemplations too long to describe here, I acquired a desire to go to medical school. During that year I also acquired a modest fluency in French and a soft longing for faraway places. The two inclinations proved to be compatible at UNC, for I discovered I could do my third-year obstetrical rotation in Europe. The chairman of the Ob-Gyn department, Dr. Charles Hendricks, has friends all over the world. When I asked him if he knew of a program in a French-speaking area he told me of his friend "Lucky Pierre" Hubinont, professor of Ob-Gyn at the Free University of Brussels. This suited me fine. After a brief exchange of correspondence, which served to oil my rusty French, the program was set for the Spring of 1973. I would spend six weeks on the Ob-Gyn service of Dr. Hubinont at the Hospital St. Pierre in Brussels, studying gynecology, speaking French, and seeing another corner of the wide, beautiful world.

The last time I traveled in Europe, I had no specialized knowledge. This time, though, I would be a medical student and would participate in a special activity of the Belgian society. Observing the role of doctors in Belgium would be only one aspect of the trip. Another important part would be a comparison of American medical practices with Belgian ones. Currently American medicine is the

most renowned in the world, but there's always another way to do something, and it always merits consideration. In these matters, though, I'd be restricted to crude impressions because I'm still a student and do not yet have the training to conduct a systematic survey and comparison of Belgian and American obstetrics and gynecology. Such a project would be enormously complex, fraught with problems of method, finance, and philosophy. My rough observations would have to suffice.

I went first to New York City, that modern Babylon, more different from North Carolina than Belgium is. After a short visit there, I flew over to Brussels, arriving late at night. I slept in the first hotel I could find, then taxied over to the hospital the next morning. Dr. Hubinont welcomed me warmly and some time later I was settled in a fifth-floor room with central heating and running water — at about the same price I'd paid for my first room in Chapel Hill. My French was better than it had been months before and the hospitality had been hopeful.

I was ready to begin.

Dr. Hubinont's service has five parts: Obstetric In-patient and Out-patient, Gynecologic In-patient and Out-patient, and laboratory facilities. The Obstetric In-patient service consists of delivery rooms (*salle d'accouchements*), the maternity ward, and the newborn nursery. New mothers keep their babies in cribs at the foot of their beds. The nurses handle feeding and hygiene, but the mothers fondle and feed their new

children as soon as both have recovered from delivery. Neonatal distress infants stay in the nursery.

The Obstetric Out-patient service has two main purposes: clinical care of the pregnancy, and preparation for delivery. The staff monitors the progress of the pregnancy by a series of clinic visits for blood pressure, urine, and cervix examinations. The preparation for delivery is a set of classes about natural childbirth. The department practices *Accouchements Sans Douleur* (literally, Birth Without Pain) or Natural Childbirth. This involves teaching the women about labor and delivery, then practice of pertinent exercises. Husbands usually accompany their wives in the classes and they are usually present at delivery. No anesthesia is given during labor and delivery.

The Gynecology service consists of two in-patient wards, an operating room, and an out-patient clinic. The clinic provides routine, ambulatory care. Patients enter the hospital either by way of the out-patient clinic or through the Emergency Room.

The laboratory facilities include a large histopathology section and a section devoted to endocrinology. The department conducts a good amount of research on placental hormones and prostaglandins and it has all the laboratories necessary for these pursuits.

Medical students have responsibilities in both the Obstetric and Gynecologic parts of the service. The house staff is divided into teams of interns and residents and two or three students are assigned to each team. The students follow and observe the

house staff as they work in each part of the service. One morning a week is spent in the operating room, and three mornings a week are spent in the out-patient clinic, either obstetric or gynecologic. The student is expected to stay in touch with his team during the day to see any special procedures that may be done, and the student is given the duty of obtaining a complete medical history and physical exam on each gynecologic patient seen by his team. The house staff usually does only the pelvic examination. In addition to these duties, the student must attend a weekly Grand Rounds presentation, and various small seminars with his attending physician. Obstetrical training comes in two five-day periods when the student must live in the hospital and take call in the delivery room. Three medical students and one midwifery student are usually on call, taking the deliveries in rotation. Overall, the service is well-organized for students and it offers a reasonable exposure to basic obstetric and gynecologic situations.

The medical work I did was not very strenuous. My schedule allowed me ample time to read and study, with weekends free for travel. Belgians begin the workday slightly later than Americans, and the student's hospital work often could be finished in a few short hours. The ten days on-call for deliveries were the hardest, but there was still enough time for study and sleep. All of my work took place in French, and after two weeks I had regained fluency enough to ask questions and follow replies, the medical terminology being similar in French and English. I can catalogue my experiences as follows:

Obstetrics: out-patient - 20 patients.
in-patient - 9 deliveries done.
5 observed.

Gynecology: out-patient - 61 patients with some repeat visits. Most were routine complaints - menstrual irregularities, abdominal pain, oral contraceptives

and abortion requests. Two patients were infertile and one patient had a unilateral breast infection.

in-patient - 7 patients - I did seven complete histories and physicals on pre- & post-operative patients.

Operations & procedures - 2 D&C, 2 hysterectomies, 1 Extra-Uterine pregnancy, 1 celiotomy to free adhesions and intervene for stress incontinence, 1 tubule ligation, abdominal approach, 1 laparoscopy, 1 culposcopy, 1 breast biopsy, incisional, 1 amniocentesis, 1 tubule insufflation, 1 vasectomy, and 2 "salting-out" induced miscarriages.

The rest of my experience consisted of seminars and Grand Rounds presentations.

I liked the program offered at St. Pierre, and I think the experiences I had gave me a good introduction to basic Obstetrics and Gynecology. I could have profited from a more strenuous schedule of hospital work, but I welcomed the time to read and travel. The six weeks were very worth while.

The rest of this report is comments and observations about Belgium. Any human society fascinates a traveler, and the perspective that medicine offers is a delicious one. The patients and their complaints give insights into that society that are found nowhere else.

A great many of the staff patients had immigrated to Belgium from southern Europe and North Africa. The husbands had come to Belgium for work, leaving their native countries behind. Many of them spoke very little French. Their wives did not visit pre-natal clinic and thus had a higher risk of complications. The Belgian government provided some social services for these people, but helping them is difficult and social programs have only small successes. I attended the presentation of a

doctoral thesis about Moroccan women's attitudes toward contraception and the author, a Moroccan himself, found very little acceptance of modern contraceptive methods, even among women who had lived in Belgium for many years. They seem condemned to large families that they can't support. The situation resembles that of many large cities in the United States with labor forces composed of immigrants from less industrialized parts of the country. Plus, in Belgium and the rest of Western Europe, the language and cultural barriers are perhaps even greater than those in the American situations. All of this was visible through the lens of the Ob-Gyn service, in the clinic and the delivery room.

Obstetrics and Gynecologic practices in Belgium differ slightly from those in the United States. Natural Childbirth and nursery arrangements have been mentioned already. Midwifery is still practiced as well, though the midwife is gradually disappearing, with fewer nurses seeking training each year. The United States needs more midwives, while Belgium seems to have enough for the time being. In other matters, I noticed no great differences. There are some small items of technique, and overall I think Americans place more faith in chemicals and instruments than Europeans do, but these are small things in practice.

Abortion is a current issue in Belgium as well as in the USA. While I was in Brussels there were several demonstrations against the anti-abortion laws presently in force. Belgian politics are very complicated, with numerous parties representing French, Flemish, Catholic, Protestant, Liberal and Conservative factions. The national parliament divides itself regularly over most issues, but it has remained against legal abortions without a serious challenge until recently. Dr. Willy Peers, a gynecologist in Brussels and a close friend of Dr. Hubinont's, made it known that he

was doing abortions in his hospital. He did this to challenge the law and the public supported him. However, he did spend a brief time in prison, and his career is in jeopardy. The Belgian medical society is considering the revocation of his medical license, though he is renowned as a man of rigid self-discipline and lofty conscience. The current law is like the one in effect in North Carolina before the US Supreme Court decision, some changes having occurred as a result of Dr. Peers' actions. But, the majority of gynecological admissions are still due to pelvic sepsis from illegal abortions. A more liberal law is needed. All of this affected St. Pierre directly, from the clinic to the operating room. Dr. Hubinont let me attend a staff conference in which the department tried to arrive at a coherent policy toward abortions, the whole assembly contorted around the sticky provisions of the current law. During the time I was there abortion requests doubled, and Dr. Hubinont is caught with trying to find a way around the law to help his patients.

Medical education in Belgium is different from that in the USA. Belgian students enter medical school when they are eighteen and study for seven years. The curriculum for the first three years is basic science in rigorous detail. The next four years are spent in hospital work — each rotation being similar to that described for Ob-Gyn. However, in the past more emphasis was placed on lecture attendance than hospital work, so that the four years of hospital service included a large amount of time in lecture.



Photograph. Robert Powell

Over a thousand students enter medical school, but the graduating classes are only one hundred to one hundred-fifty, most of the attrition occurring in the first two years. The students have examinations only at the end of the year and my friends in Brussels were in the midst of the final exams of their careers. All the exams are given orally and studying for them is next to impossible but my friends were accustomed to it and seemed no more anxious than I would be faced with a multiple-choice exam. Dr. Hubinont had tried to institute some written examinations, but neither the faculty nor the students accepted them very well.

The students came from everywhere in the world. In six weeks I met three Haitians, three Israelis, two Canadians, one Syrian, and several students from Zaire (the former Belgian Congo). Not to mention the Belgians, both Flemish and French. There were Americans as well — most of them from New York City. All this was a great congregation of nationalities and a credit to Belgian medicine, but the Belgians will restrict foreign application in the future because of increasingly limited space in their programs. They intend to have quotas for all foreign students and all of them will be much reduced from present numbers. The Americans will be reduced quite severely I expect. The Belgians must preserve places for their own citizens, and this will damage the international ambience in the medical school.

The medical school reflected the bilingual character of Brussels as well as its international flavor. By law,

the faculty had to include a number of Flemish-speaking professors and the unwritten rule required everyone on the staff to speak both French and Flemish. Quotas had been established for both French and Flemish students, and all of the attendant administrative matters were quite complicated. The history of Belgium dwells in this situation, the nation having been created from the two groups with different languages and cultures. There has been great bitterness in the past between the French and the Flemish, but for me, their problems made my travel more spicy, giving me many a marvelous conversation in a city with two languages.

One brief observation on student life — it resembles itself all over the Western World, even to the point of common songs and popular pursuits. The Belgians thought about the same things, read many of the same books, and listened to many of the same records I did. The differences are subtle and perhaps not as important as the similarities.

A dry catalogue of hospital duties and crude social science can't convey all my feelings about the trip. "Nine deliveries" says nothing about the little Italian who loved me so because I delivered her baby, or the loud, passionate Moslem prayers shrieked by the Moroccan women as the labor pains grew. Or my travels — a visit to Bastogne, where I contemplated the scythe-like flight of the swallows through the arches of the American monument to the Battle of the Bulge. Thirty years ago I might have been there clutching a rifle, the

air filled with demons. Or the gilded towers and turret-tops of the Grand-Place in Brussels, glowing at night under lights, softly misted by the constant Belgian rain. Somehow, when it's in French and it's faraway, life is colored as a dream. But, it is real there too, in spite of all the romance one can weave for himself. I enjoyed it all tremendously, and I learned my medicine. I couldn't beat that anywhere.



This is the first of a series of articles by faculty and alumni. It is hoped these experiences will lead to a vigorous exchange of ideas about health care in North Carolina. The views of the writers will not necessarily reflect those of the UNC School of Medicine.

by Raymond Wheeler, M.D.

Breaking Out

A specter hangs over children born into poverty. Hunger and malnutrition still affect many. Tangible environmental hazards, such as impure water and inadequate housing, combined with the less tangible hazard of being born into poverty — mean that simply by accident of where these children will grow to adulthood following the same pattern as their parents. They are often ill, their resistance to infection lowered, their ability to learn and to perform their life tasks irreparably impaired. Physically stunted, mentally dulled, emotionally warped, they are children who do not have the capacity to engage in the sustained physical or mental effort which is necessary to succeed in school, learn a trade, or assume the full responsibilities of citizenship in such a complex society as ours.

This is not rhetoric. Some grim and little publicized statistics about health in North Carolina disclose an appalling reality which has profound implications for the future social and economic well-being of our state.

In the South today, there are 10.5 million people living at, or below, federally defined poverty levels. This is half the national total. As stated, a battle begins at birth which is lost at birth.

In North Carolina, one of every 10 infants is born prematurely and 15 per cent of premature babies do not survive. Premature birth is associated with reproductive abnormalities and complications of pregnancy, but maternal nutritional status is a major factor in premature births. There is a direct relationship between infant birth weight and infant mortality. Prematurity is often related to impairment of intellectual capacity, which has disturbing implications when we consider the high incidence of premature births in our state.

1972 data shows that North Carolina ranks third in the nation in infant mortality rates (Mississippi and the District of Columbia rate first and second). In the post-neonatal period (28 days to one year of age) the non-white child is four times as likely to die as the white child and the chief cause of death is infectious disease — curable diseases such as pneumonia, influenza and gastroenteritis.

According to the Governor's Nutrition Survey 43% of pre-school children in North Carolina have nutritionally inadequate diets and 46% of North Carolina school children are shorter in height than the height of the average child in the U.S.

Our rate of Selective Service rejections on health grounds in 1970 was the fourth highest in the nation, with 63 of every 100 draftees rejected for a physical defect. Five causes of death in North Carolina exceed the national average: high blood pressure, kidney disease, and illness of the newborn being the important categories.

There is little doubt, when these statistics are analyzed, that poor health and inadequate medical care, are directly related to economic status and to the number of poor people who live in North Carolina (more than 20% of the population).

When infant mortality is broken down by race, the white infant mortality is no greater than the average for the U.S.

Non-white infant mortality is considerably higher than the national average and more than twice the rate for white infants in N.C.

According to the Governor's Nutrition Survey, malnutrition is directly related to inadequate income.

In North Carolina 342,000 families, nearly 20% of the total families, have annual incomes at or below the poverty level. Most of these families, unless they receive food assistance, are likely to have nutritionally inadequate diets.

Among the poor, four times as many people have chronic physical disabilities as compared to the non-poor.

Among the working age groups, low income people have three to four times as many disability days and have more and longer hospitalization.

A non-white child from 0 to 4 years of age is twice as likely to die as a white child of the same age.

A non-white adult from 25 to 44 years of age is three times as likely to die as a white adult of the same age.

The impact of illness and disability to this degree is enormous. All available data consistently reinforce the refrain that children born of, and into, poverty are malnourished, are more frequently ill, and often develop irreparable damage to the central nervous system. As a result, they are as adults, slow learners who live lives of poverty, produce children who grow up in the vicious cycle which condemns them to lifetimes of marginal function. Their lives are characterized by high rates of failure in school, behavioral disturbances, physical disabilities, and low levels of employment and productivity.

For many years, thoughtful health professionals have recognized that if the cycle of poverty-related illness is to be broken, other means must be found to deliver health care than are presently available. Our present system of health care is fragmented, oriented toward the convenience of



the providers, the physician and hospital, and available primarily to those who can afford to pay for it.

If the business, political, and professional leadership of North Carolina is seriously concerned with improving the health of the people of North Carolina and thereby improving our economic and social health as well,

it must find ways to alter the existing health care system which is underserving the poor.

Governor Holshouser's proposal for the delivery of medical services to rural areas is less than a modest start in this direction. Fourteen or Fifteen rural clinics, established and funded with an appropriation of no more

than a million and a half dollars over a period of two years would hardly be able to provide any but the most minimal medical services, involving primarily immediate attention to the most acute and pressing medical problems. This would be true even if it is assumed that significant leadership and resources can

be obtained from the communities to be served. Hopefully, such clinics might serve as the bases for more adequate and more comprehensive health centers in the future.

Other models already exist in this country which have been remarkably successful in developing methods for delivering total health care to both urban and rural poor. These are the Federal Government's Comprehensive Health Service Programs, administered by OEO and the Department of H.E.W. The programs, which function through neighborhood or community comprehensive health centers, have operated on the theory that, in order to improve the health of poor people, care must encompass a host of vital services, including in addition to clinical primary care, such services as improvement of environmental health conditions, laboratory tests, x-rays, dental care, medicines, eyeglasses, child care, free transportation to health centers, nutritional and educational services.

The team approach, in which the patient has access to the whole range of medical and health services specialists, available under one roof, is the vehicle. Treating the patient in a total manner, viewing his medical needs in conjunction with the social and environmental factors which perpetuate them, is the objective.

We tend to forget that health is a broad social concept, encompassing not only illness but complex inter-relationships of genetic, psychological, social, environmental, and pathological factors that affect the individuals ability to perform his life tasks effectively. Little is accomplished by treating a child for a draining, purulent otitis media if the child must return to a family situation in which he remains malnourished and in which he is subjected, by virtue of overcrowding and inadequate protection from heat and cold, to repeated exposure to subsequent respiratory infections. It does no

good to treat a child for intestinal parasites or bacillary dysentery, if the child returns to a home without adequate sanitary facilities and must drink contaminated water.

In the modern world, housing, nutrition, accident prevention, sanitation — clean water, food, streets, and homes — have improved health conditions more than all of the hospitals, clinics, and doctors combined. Health indices seem much more related to poverty levels within states than to numbers of doctors. A program of national health insurance seems desirable and inevitable, but it may serve to increase the demand and therefore the cost of medical care while doing little to improve either mortality or morbidity statistics — unless we are willing to put more effort into the areas of adequate nutrition, housing, and sanitation, especially among those whose incomes are low.

Most existing health programs today do not reach those whose need is greatest, just as the food programs have not fed those who are hungriest. There is one exception — the program of neighborhoods comprehensive health centers referred to above. This type of program is designed to deal with health and environment as it must be dealt with. Ways must be found to establish and develop this type of program, extend it not just to the rural poor, but also to the urban poor, where its kind of approach to health problems is so desperately needed.

Then we can begin to improve the health of children, deliver comprehensive health services to adults, improve the conditions in which women have children, and offer assistance to parents in limiting the size of their families. This kind of program deserves the enthusiastic support of our political and professional leadership in North Carolina.

Editor's Note: Dr. Wheeler, a member of the Class of 1941, received his M.D. degree from Washington University. A Sanford native, he is a Charlotte internist with a special interest in the medical problems generated by malnutrition and sub-standard living conditions. Dr. Wheeler received the highest honor the UNC School of Medicine bestows upon alumni and friends, the Distinguished Service Award.

by Christopher C. Fordham III, M.D., Dean

126 MacNider

As most of you know, the Medical School is a very busy and exciting place these days with a full measure of challenges.

The size of the medical student body has grown from the high 200's to the low 400's in the past five years. The graduate training programs in basic medical sciences have remained strongly productive, despite serious funding difficulties. The clinical training of house officers and fellows in all of the major specialties of medicine has increased in scope and number of clinical trainees and continues to attract outstanding people from all over the country, a great many of whom stay in North Carolina to practice medicine. The Medical Allied Health programs are in the process of reorganization into a department in the Medical School; with the nurture of a strong medical faculty, the allied programs in the School of Medicine should be among the best in the country and should contribute to innovative approaches to health care and health education.

Among the new programs of major importance which will begin 1 July of 1973, may be included:

1. The beginning of a family practice residency at the North Carolina Memorial Hospital with six first year residents and three second year residents. In addition to the chairman and the faculties of the major clinical departments, the development of this program has been greatly aided by Dr. William Bakewell who has served as coordinator of the residency and Dr. Peter Curtis who has been in the process of organizing the model family practice unit.
2. The establishment of a department of Medical Allied Health Professions, referred to above, with Dr. Robert Crounse as the first chairman.
3. The establishment of a Department of Hospital Laboratories which will, for the first time, centralize the clinical laboratories of the North Carolina Memorial Hospital. This

Hospital department will be chaired by Dr. William McLendon, who will also be a professor in the Department of Pathology. As chairman of the Hospital Department of Clinical Laboratories, Dr. McLendon will be responsible to the General Director, Hospital Board, and Executive Committee of the medical staff. Mr. Danielson, the faculty and I are



all enthusiastic about this long-awaited effort to centralize the clinical laboratories of the North Carolina Memorial Hospital.

Progress during the past year in the concept of a university medical center without walls has been truly impressive. Depending heavily upon a very strong home base in Chapel Hill, the faculty, under the guidance of Mr. Glenn Wilson, Associate Dean for Community Health Services, has continued the strong movement toward clinical teaching programs throughout the state which was initiated by Dr. Berryhill in 1965. We now have affiliations with nine hospitals, 22 full time faculty located in these hospitals, in addition to the volunteer and part time faculty there, and we anticipate more than 200 medical student rotations during the forthcoming academic year. These affiliated hospital programs depend, in large measure, not only on the strong base in Chapel Hill and the

air transportation service which facilitates exchange, but on the commitment and understanding of the physicians, hospital administrators and their colleagues in these affiliated hospitals, to develop and carry out high quality educational programs . . . Upon this background, the University Medical School, together with sister health schools and community hospitals, achieved the largest federal contract in the history of the University for the development of Area Health Education Centers. This is a concept which will be expanded elsewhere in this Bulletin and the essence of which is a partnership between the University and regional centers for health education. The programs now touch 31 of the 100 counties and may be expected to grow in productivity and scope.

This is but a glimpse of the past year's activities at the School. Our students have continued to do exceedingly well in the quality of their internships. Our faculty continues to compete favorably for resources on the national scene, in education and research. The North Carolina Memorial Hospital continues to serve patients and physicians from every county of the state, and the new additions to our faculty and student body continue to be of very high caliber. Important new programs have begun, and a strong partnership with the regional centers throughout the state is developing. It is ironical and distressing that federal funding is threatened in important areas at a time when institutions such as our own are attempting to increase the scope and productivity of our efforts on a number of fronts to help meet the needs of the citizens whom we serve. We continue to have solid support from the State of North Carolina and from our alumni and friends, and we will continue to compete vigorously at the national level. I cannot help but be very optimistic and grateful.

Graduation: 1973

This Bulletin of the UNC School of Medicine replaces the annual Bulletin. Therefore, albeit late, is a summary of the graduation exercises and activities of the Class of 1973.

The formal graduation exercises were preceded by the annual Student Faculty Day, Saturday, May 5, 1973. This consisted of the usual spoof of the faculty by the four classes. Perhaps the highlight was the "Broadway Musical" produced by the Class of 1975. Titled "Healer Man," the author, Donald Fidler of Boone, N. C., depicted one student's journey through medical school. He planned a career in Family Medicine and his ultimate success. Perhaps there is a message here, namely the real and increasing interest in primary medical care by our students.

The plays and skits were serious at times with the announcement of awards to the house staff and faculty:

The Professor Award: John Curtis Parker, M. D. - Associate Professor of Medicine and Assistant Professor of Biochemistry

The Medical Basic Science Teaching Award: 1. David Goldman, M.D. - Assistant Professor of Medicine and Pharmacology

The Henry C. Fordham Award: Ardis Dee Hoven, M.D. - Resident in Medicine

The Outstanding Intern Award: Thomas Michael Bashore, M.D. - Intern in Medicine

The William deB. MacNider Award: James Edward Peacock, Jr., '75

The Isaac Hall Manning Award: David Alan Grimes, '73

The James Bell Bullitt Award: Venita Newby Thweatt, '73

The Medical Faculty Award: David Alan Grimes, '73

The Roche Award: Stephen Alan Bernard, '73

The George C. Thrasher, Jr. Award: Elisabeth Anderson Keller, '73

The Upjohn Award: Dale Alan Newton, '73

The Heusner Pupil Award: Thomas Welborn Bouldin, '74

The Mosby Book Senior Awards: Frank Brown Sloop, Jr., '73
Frederic Fries Bahnson III, '73

The CIBA Award: Lloyd Karr Comstock, '73

The Lange Senior Awards: David Read Patterson, '73
Michael Abraham Wall, '73

AMWA Scholastic Achievement Citation: Karen Hendrix Rhea, '73
Elizabeth Hooper Jackson, '73

Alpha Omega Alpha Honor Medical Society:

Class of 1973
Stephen Alan Bernard*
Charles Hillman Edwards II
David Alan Grimes*
Elizabeth Hooper Jackson
John Charles Jennette
James Nello Martin, Jr.
Dale Alan Newton*
David Read Patterson
Richard Norwin Pierce
Karen Hendrix Rhea*
Hugh Gaither Shearin*
Frank Brown Sloop, Jr.
Stephen Wayne Smith
Michael Abraham Wall

Class of 1974
Robert Martin Alsop
Thomas Welborn Bouldin
Charles David Collins
Terry Lyn Overby
David Earl Tart
Daniel Castile Vinson

* Elected Junior Year

Following the morning skits, the activities moved to Storybrook

Farm for an afternoon of barbecue, beer, fun and games. The day was capped with a dance at Legion Hall.

Graduation day was Sunday, May 13. An address was given by David A. Grimes, M.D., Class President, and Dr. Newton Fischer, Professor and Chief of Otolaryngology.

Introduction of the Class of 1973 was made by Dean Fordham, and the hooding was performed by Robert L. Ney, M.D., Chairman, Department of Medicine.

Editor's Note: Dr. Sapp, Class Advisor for 1973, was given the "Mother of the Year Award" at the annual dinner sponsored by the UNC Medical Alumni Association to welcome new members. He hopes to photograph his "award," complete with hearts and cupids.

1973 Internships & Residencies

Joe Agsten
North Carolina Memorial Hospital
Chapel Hill, North Carolina

Fred Bahnson
University of Virginia Hospital
Charlottesville, Virginia

Charles Baker
Medical Center Hospitals of Vermont
Burlington, Vermont

Ken Banks
Franklin Square Hospital
Baltimore, Maryland

Ernie Beale
William A. Shands Teaching Hospital
Gainesville, Florida

Ruffin Benton
University of Virginia Hospital
Charlottesville, Virginia

Steve Bernard
Presbyterian Hospital
New York, New York

teve Billick
North Carolina Memorial Hospital
Chapel Hill, North Carolina

esse Blackman
North Carolina Baptist Hospital
Winston-Salem, North Carolina

Bill Butler
Naval Hospital
Portsmouth, Virginia

Tom Cannon
North Carolina Memorial Hospital
Chapel Hill, North Carolina

Nady Cates
Akron City Hospital
Akron, Ohio

Rusty Clark
University of Florida Affiliated
Hospitals
Gainesville, Florida

Mel Clayton
University of Maryland
Baltimore, Maryland

Barr Coleman
University of Utah Affiliated Hospitals
Salt Lake City, Utah

Lloyd Comstock
Highland Hospital of Rochester
Rochester, New York

Frank Davis
University of Pennsylvania Hospital
Philadelphia, Pennsylvania

Tommy Dempsey
University of Florida Affiliated
Hospitals
Gainesville, Florida

Chuck Edwards
Duke Medical Center
Durham, North Carolina

Bill Fahrner
Confederate Memorial Medical Center
Shreveport, Louisiana

Bill Federal
San Francisco General Hospital
San Francisco, California

William Ferguson
University of Utah Affiliated Hospitals
Salt Lake City, Utah

Bob Forstner
L. A. County - USC Medical Center
Los Angeles, California

Ruffin Franklin
Childrens Memorial Hospital
Chicago, Illinois

Wayne Franklin
University of Connecticut Affiliated
Hospitals
Hartford, Connecticut

Robert Fritz
University of Virginia Hospital
Charlottesville, Virginia

Terry Fry
North Carolina Memorial Hospital
Chapel Hill, North Carolina

Marshall Goldberg
Medical College of Virginia
Richmond, Virginia

Mike Gooden
L. A. County - USC Medical Center
Los Angeles, California

Donald Goodman
Charlotte Memorial Hospital
Charlotte, North Carolina

Blake Goslen
William A. Shands Teaching Hospital
Gainesville, Florida

Ira Greene
University of Arizona Affiliated
Hospitals
Tucson, Arizona

Dan Griffin
Charlotte Memorial Hospital
Charlotte, North Carolina

David Grimes
North Carolina Memorial Hospital
Chapel Hill, North Carolina

Bonner Guilford
North Carolina Memorial Hospital
Chapel Hill, North Carolina

Crit Harley
Charlotte Memorial Hospital
Charlotte, North Carolina

Mike Harper
Medical University of South Carolina
Charleston, South Carolina

Robert Harry
University of Virginia Hospital
Charlottesville, Virginia

Ed Hersh
Pennsylvania Hospital
Philadelphia, Pennsylvania

Beth Jackson
Strong Memorial Affiliated Hospitals
Rochester, New York

Dan Jackson
Rochester General Hospital
Rochester, New York

Earl Jenkins
North Carolina Memorial Hospital
Chapel Hill, North Carolina

Charles Jennette
North Carolina Memorial Hospital
Chapel Hill, North Carolina

Dennis Johnson
King's County Hospital - State Univ.
of N.Y.
New York, New York

Colin Jones
University of Wisconsin Hospital
Madison, Wisconsin

Stan Jordan
University of California Hospital
Los Angeles, California

Steve Kaufman
North Carolina Memorial Hospital
Chapel Hill, North Carolina

Libby Keller
Yale-New Haven Medical Center
New Haven, Connecticut

John Long
North Carolina Memorial Hospital
Chapel Hill, North Carolina

Dick Low
University of Kansas Medical Center
Kansas City, Kansas

Jim Martin
North Carolina Memorial Hospital
Chapel Hill, North Carolina

Jim Maynard
North Carolina Memorial Hospital
Chapel Hill, North Carolina

Rusty Maynard
University of Virginia Hospital
Charlottesville, Virginia

Clay Newsome
Vanderbilt University Hospital
Nashville, Tennessee

Dale Newton
North Carolina Memorial Hospital
Chapel Hill, North Carolina

Gary Niess
University of Alabama Medical Center
Birmingham, Alabama

Malone Parham
Duke University Medical Center
Durham, North Carolina

David Patterson
North Carolina Memorial Hospital
Chapel Hill, North Carolina

Richard Pierce
Rhode Island Hospital
Providence, Rhode Island

Henry Purvis
Memorial Hospital
Savannah, Georgia

Mac Reavis
North Carolina Memorial Hospital
Chapel Hill, North Carolina

Robert Reddick
North Carolina Memorial Hospital
Chapel Hill, North Carolina

Karen Rhea
Vanderbilt University Hospital
Nashville, Tennessee

Mike Robinson
University Hospitals of Ohio
State Univ.
Columbus, Ohio

Stewart Rogers
Milwaukee County General Hospital
Milwaukee, Wisconsin

Donald Rollins
University of Texas
San Antonio, Texas

Roy Ruff
Montefiore Hospital
New York, New York

Stanley Rule
University of Alabama Medical Center
Birmingham, Alabama

David Sharp
North Carolina Memorial Hospital
Chapel Hill, North Carolina

Hugh Shearin
Medical University of South Carolina
Charleston, South Carolina

Susan Sherman
Presbyterian-University Hospital
Pittsburgh, Pennsylvania

Frank Sloop
University of Virginia Hospital
Charlottesville, Virginia

Wayne Smith
North Carolina Memorial Hospital
Chapel Hill, North Carolina

Tim Spiegle
George Washington University Hospital
Washington, D.C.

Ronnie Sprinkle
University of California Affiliated
Hospitals
Los Angeles, California

Jim Stratton
Hershey Medical Center
Hershey, Pennsylvania

Tom Succiu
Duke University Medical Center
Durham, North Carolina

Dan Summerlin
University of Connecticut Affiliated
Hospitals Hartford, Connecticut

Joe Swaim
Duke University Medical Center
Durham, North Carolina

John Thomas
Thomas Jefferson University Hospital
Philadelphia, Pennsylvania

Venita Thweatt
Freedman's Hospital
Washington, D.C.

Doug Tilt
University of Alabama Medical Center
Birmingham, Alabama

George Underwood
Madigan General Hospital (Army)
Seattle, Washington

Mike Wall
Massachusetts General Hospital
Boston, Massachusetts

Robert Walther
University of Miami Affiliated
Hospitals Miami, Florida

Bill Whisnant
University of Tennessee Memorial
Hospital Knoxville, Tennessee

Joe Williamson
North Carolina Memorial Hospital
Chapel Hill, North Carolina

John Estes will do a year of research
before beginning post-graduate training

In Memoriam

OUT-OF-STATE

John W. Deyton - St. Louis, Mo. - '26
Clayton M. Eley - Norfolk, Va. - '14
Hazel McLeod Riggins, Seattle - '22

NORTH CAROLINA

Sidney Eli Buchanan - '10
Henry Lilly Cook - '16
Alpheus W. Disosway - '03
Eric Ellington - '64
Jacob Luther Fritz - '34
James Brownlee Hall - '31
John Robert Lowery - '02
J. Gaddy Matheson - '27
Joseph Altira McLean - '24
Charles White Millender - '15
Ashley Curtis Norfleet - '23
Ivan M. Procter - '13
Louis J. Ring - '30
Robert Alexander Ross - '22
Sidney S. Smith - '23
Joy V. Sykes - '21
W. Royster Young - '34

Who's where

20's

M.D. Bonner, '28, has been honored by the Piedmont Tuberculosis and Respiratory Disease Association. A scholarship for the study of respiratory diseases will be given each year to an outstanding intern at Moses Cone Hospital.

Four members of the Class of '22 have made a generous donation to the Health Sciences Library for the purchase of books for the History of Medicine Room. The emphasis is to be placed on Americana in general and Caroliniana in particular. The library has already acquired several items from the fund, the most notable being a copy of "An Essay on Fevers" published in 1768. The donors were B.W. Roberts, Bryan P. Warren and Blackwell Sawyer. The fourth donor, McLeod Riggins, has died since the gift was made.

30's

James M. Alexander, '31, was honored at the annual fall meeting of the North Carolina Society of Internal Medicine. Dr. Alexander was its first president. He was also recognized at the same time by the President of the North Carolina College of Physicians. Both groups honored Dr. Alexander for his contributions to the practice of medicine and medical education.

G. Clyde Shinn, '31, was one of five doctors honored in China Grove on Sunday, October 7, 1973. About 350 of the town's 8,000 turned out, bringing pies, cakes, fried chicken and handshakes for the three physicians, the optometrist and dentist who treat them. Dr. Shinn and his associates received engraved plaques, and one of the babies Dr. Shinn delivered had grown big enough to amuse himself by making faces in the shiny brass of the plaque. Dr. Shinn established his general practice in China Grove in 1940.

40's

Frank R. Reynolds, '41, is President-Elect of the North Carolina State Medical Society for 1973-74.

Ira Abrahamson, Jr. '46, is an Assistant Clinical Professor of Ophthalmology at the University of Cincinnati School of Medicine. He, his father, and another physician received the first award for the "Outstanding Scientific Exhibit" by the American Academy of Family Physicians. They also received a Certificate of Merit Award for the best ophthalmological exhibit at the annual AMA meeting in New York. The prize-winning exhibit used more than 1,000 photographs to illustrate anterior segment eye diseases.

David S. Citron '43, has joined the full-time faculty at the Charlotte Memorial Hospital as head of the Family Practice Program there. There will be a model family practice unit, and David is excited about the potential the program has in a city predominated by specialists. He is also President of the Mecklenberg County Medical Society this year, and when he studied the membership roster, he learned that not one family practitioner had located in the area during the last five years. That prompted him to accept his new position.

50's

T. Albert Farmer '57, formerly an associate dean at the University of Alabama, is now dean of the University of Tennessee School of Medicine.

William B. Wood '56, Associate Professor in the Department of Medicine, UNC School of Medicine will study the role of the medical specialty concept in medical education and in health care delivery. His base of operation will be Erompton Hospital in London, but he will visit other medical education centers in England. Dr. Wood will return in June, 1974.



Laurence Elliott Earley, '56, Professor of Medicine and Physiology at the University of Southern California - San Francisco, has been named chairman of the Department of Medicine at the University of Texas School of Medicine at San Antonio.

Julian Albergotti '55, is President-Elect of the 430-member Mecklenburg County Medical Society. He takes office in December, and again in March becomes President of the UNC Medical Alumni Association.

William G. Thurman '52, was recently named the 21st dean of the Tulane University School of medicine. He had been chairman of the Department of Pediatrics at the University of Virginia School of Medicine at Charlottesville and director of the Center for Delivery of Health Care of the University of Virginia.

Laurence Elliott Earley, '56, has been named Professor and Chairman of the Department of Medicine at the University of Texas Medical School at San Antonio. Since 1968, he had been a professor of medicine and physiology at the University of California - San Francisco.

Julian S. Albergotti, Jr., '52, succeeds David S. Citron, '43, as President of the Mecklenburg County Medical Society in 1974.

William B. Blythe '51, Professor of Medicine and Director of the Clinical Research Unit, will spend six months in London working with a friend, Dr. H.E. DeWardener at Charing Cross Hospital. The Blythes are scheduled to leave in January and will return in June.

60's
Lawrence Cutchin, '62, received the 1972 Young Internist of the Year award from the N.C. Society of Internal Medicine for his contributions to his "physician deprived area," as well as his contributions in education.

Cutchin has instituted new continuing education programs, and has been active in implementing new systems of health care delivery, the society noted.

Kelman Cohen, '63, is now Chairman of the Division of Plastic Surgery in the Department of Surgery at the Medical College of Virginia.

T. Boyce Cole '62, is an Assistant Professor of Surgery in the Division of Otolaryngology at the Duke University Medical Center. The Coles have three sons.

L. Morgan Hale '61, and Robert V. Hale '67, opened their offices, the Chapel Hill Ophthalmology Clinic, in August.

Frank McCain '60, is now in solo practice in Winston-Salem, specializing in the treatment of allergies. He and his wife, Margaret, a graduate of the 1961 Class of the UNC School of Nursing, have four children.

60's
Noel McDivitt, '64, has joined the UNC faculty as an assistant faculty. Before July 1, 1973 he was Chief Resident. In 1973, he was given the \$1,000 Nathan A. Womack Scholarship Award. The decision is based on the recipients' general excellence in teaching clinical investigation and patient care. He has twice been the recipient of a National Institutes of Health Cancer Traineeship and the Southern Medical Association's Residency Grant.

John Powell, '68, was named Assistant Chief of the Department of Obstetrics and Gynecology at the 2nd General Hospital in Germany this September. "I have had five articles published in various Ob-Gyn journals in the last year. I have done \$345,480 worth of deliveries, surgery and out-patient care for the Army in the past year, while my salary was less than \$20,000. The main consolation is the opportunity to see Europe," he wrote. His mailing address is Box

25, 2nd General Hospital, APO NY 09180.

Camilla A. Proctor '68, has been appointed to the University of North Carolina Infirmary Staff.

E. Frank Shavinder '68, reports that he and his family are in Albany, Ga. where he is stationed with the Navy. He finished a four-year residency in obstetrics and gynecology at the Medical University of South Carolina in Charleston before entering the service. The Shavinders plan to return to North Carolina in two years.

Rudolph I. Mintz '67, has joined the Kinston Clinic. He is specializing in obstetrics and gynecology and his office address is 400 Glenwood Ave.

Howard T. Hinshaw '66, is now associated with the Nalle Clinic in Charlotte. He is an endocrinologist and completed his residency at Parkland Memorial Hospital in Dallas and a fellowship at N.C. Memorial Hospital.

Takey Crist '65, has entered private practice in obstetrics and gynecology in Jacksonville, N. C.

Jesse R. Peel '65, is an Assistant Professor of Psychiatry at Vanderbilt University School of Medicine. In addition, he is Clinical Director of the Adult Psychiatric Division of Vanderbilt University Hospital.

William Knox Kinlaw, Jr., '64, has entered private practice in Decatur, Georgia. His office address is: Suite 241, 365 Winn Way, Decatur, Georgia, 30030. Friends report that he and his family are living in Atlanta.

J. Phillip Goodson '63, has joined the surgical practice of Sinclair, Stallings and Hartzog in Raleigh. Their offices are at 704 W. Jones Street.

70's
Baxter C.J. Leonard, '72, can be reached by mailing letters to: Baxter C.J. Leonard, Lt. M.C. USNR, RAS 9th Schwab, Third Marine Division, FPO S.F. Calif. 96602.

When you went to him, you got not only a doctor, but a friend.



Robert A. Ross, M.D.

He was a big man, in a lot of ways — so big that a lot of people never knew his first name, and many never called him “doctor.” He was known across the nation simply as Daddy Ross.

This familiarity robbed him of no dignity. His full girth, his white hair, his erect bearing and his subtle air of unassuming and unstrained authority made him dignified enough. “Daddy” just made him seem as fallibly human as his patients, which is a good thing, because most of his patients and their husbands were trying to cope with either approaching parenthood or gynecological problems, matters that cut pretty close to the quick. When he died Sunday, we lost one of the best friends either a mother or a father ever had.

And that, said one of his colleagues, was one of Daddy Ross’s most notable traits: “When you went to him, you got not only a doctor, but a friend. He just liked people, that’s all. He didn’t know how to bore anybody. I think he went to medical meetings all over the country not to learn anything from the speakers, but to meet his old friends.”

Friendship, for Daddy Ross, took some interesting turns. Having started the Gynecology and Obstetrics departments at both Watts and N.C. Memorial hospitals, he is credited with also having prevented a great deal

of civil war from developing between Duke and UNC simply by maintaining friendships. One way he maintained friendships was never to pussyfoot. The dean of the Duke medical school once asked Daddy why the dean of the UNC medical school disliked him.

“He doesn’t dislike you,” said Daddy. “He just doesn’t trust you.”

He was a widower, and when asked once why he never remarried, he replied that the only thing old people had going for them was money. And in a speech one time, he referred to menopause as “the pause that refreshes.” It is hard not to listen to a man like that.

But it was more than wit that drew people’s rapt attention to whatever Daddy Ross said. His clinical judgement gained him immense respect from his colleagues, and his voice also became memorable through his sharp assessment of national medical problems. In particular he was concerned with patient care — a virtue that sometimes gets obscured in the academic and investigative activities of a teaching hospital. But Daddy Ross did not forget that hospitals revolve around the sick, and that certain organizational policies are necessary to preserve this patient-institution relationship in proper perspective.

Most people assumed that his nickname resulted from his lifelong association with babies (except in the Navy, of course, which he entered at the bottom during World War I, and retired from in 1962 as a Rear Admiral in the Naval Reserve). But this was not the case.

The nickname was bestowed on him during his undergraduate days at UNC, when he was a member of ATO Fraternity. He was the only ATO who didn’t drink, and since the ATO’s were a notably wild crew in those days, Robert A. Ross quite often ended an evening putting his brothers to bed. He was so conscientious about this that the boiled boys he ladled upstairs called him Daddy. Another service to those in need of help — as well as all the others.

Reprinted by permission of
The Chapel Hill Newspaper

Mrs. Ethel Nash



Mrs. Ethel Nash, 63, professor, author and consultant in marriage and family counseling, died in March.

She was an associate professor at the University of North Carolina School of Medicine and a senior research associate at the Carolina Population Center.

A native of England, Mrs. Nash received her education at the University of Liverpool, Yale Clinic of Child Development, and the University of North Carolina.

She contributed to many books and journals, but was best known for her work as senior editor of “Marriage Counseling in Medical Practice.”

She is survived by her husband, Dr. Arnold S. Nash, and two sons, A. E. Keir of Santa Barbara, Calif., and David C. Nash of Chapel Hill.

“I don’t want to tell you what to do, But...”

by Cheree Briggs, Editor



A banner headline in the September 10, 1941, issue of The Charlotte Observer said, “Mecklenburger Named Head of UNC Medical School.” A sub-headline added, “Trustees Make Natural Choice.”

The “natural choice” was Dr. Walter Reece Berryhill, a product of Steele Creek Community (near Charlotte), the University of North Carolina and Harvard Medical School. Dr. Berryhill was considered a natural choice not only by the trustees, but by his colleagues as well.

Dr. Robert A. Ross, Chairman Emeritus of the Department of Obstetrics and Gynecology, recalls: “At 41, Reece was young for a dean. Back then, becoming dean was much like becoming chairman of a Congressional committee is now. Often one got there by seniority. But nobody was surprised when Reece was made dean. He was the one everybody had his eye on.”

Dr. Berryhill, however, recalls the anxieties of that first year. Charged with guiding a faculty composed of his own former teachers, the educator was not sure that he was the man who could shape the two-year medical school into a four-year, degree-granting institution. (This had been the goal of the School of Medicine for about 60 years. Before he joined the faculty, Dr. Berryhill obtained a written statement that the University’s administration would help the medical school reach that goal.)

His predecessor, however, had no doubts that Dr. Berryhill could do what had not been done before.

Dr. Isaac Manning, Dean Emeritus, told Dr. Nathan Womack, now Chairman Emeritus of the Department of Surgery, that he knew Dr. Berryhill would be a successful dean. “He has all the qualities of a Presbyterian deacon,” Dr. Manning said. “He never lets a matter drop.”

The deacon-like doctor was very nearly a minister instead. Dr. Berryhill was so serious about becoming a minister that he came to Chapel Hill to study English, Latin, and Greek.

I thought all ministers needed to be well-grounded in the classics," he says. "But some time during my sophomore year, I realized my enthusiasm for the ministry was not as great as I thought. I looked around for another way to help people, but I simply cannot tell you why I chose medicine. I don't know."

Dr. Ross, also a Steele Creek boy, considers it reasonable that a young man in that time and place would consider the ministry. After all, he was a good Scotch-Presbyterian in a strict Scotch Presbyterian community. "We were in church every Sunday," Dr. Ross recalls. "No playing baseball afterwards, either. Having fun was a sin. And we were back in church on Wednesday night, complete with kerosene lamps and that flying."

But Dr. Berryhill's staunchly Calvinistic family was a warm one. Recalling how he dreaded telling his family he wanted to go to the University of North Carolina instead of Davidson College, he found that they readily accepted his choice.

"They said it was my life, and they'd help me any way they could. Then my father got the UNC catalogue and saw the names of many of his friends' children. He decided maybe Chapel Hill would do just fine."

Choosing to come to Chapel Hill in 1917 was one of the most significant decisions the young man ever made. At that time, Dr. Womack says the campus was populated with "just a bunch of country boys, and I do mean country boys. I learned two priceless things in my two years at medical school: the discipline of learning and how to chew tobacco while doing it."

Apparently Dr. Berryhill learned how to learn, too. He made Phi Beta Kappa, accumulating a number of extra-curricular honors as well. Some time during his junior year, he decided that he would not be a minister. After making the decision to become a doctor, he had to spend two years meeting science require-

ments for admission to medical school. He had had only physics before he walked into chemistry. "They taught no science in country schools then," he says.

Another significant event took place that year, although it didn't seem important at the time. He went to Peace College one Sunday afternoon to visit a popular Charlotte girl. When he arrived, she already had a parlor full of callers. His hometown friend asked Miss Norma Connell to spend some time with him, and she agreed. They went to the college chapel — she sitting in one pew, and he in the one in front of her.

As a student and admirer of Professor Horace Williams — who taught his philosophy students to examine all their religious beliefs — the college junior teasingly tested Miss Connell much the same way he had been challenged in the classroom. "Could God fry an egg on a snowball?" he asked her. She took him seriously. As the young president of the YWCA was "a touch pious" she decided to go back to her room and pray for him. "That young man said such dreadful things. I didn't want him to go to hell."

Ten years later, Miss Connell became Mrs. Berryhill, and by that time she herself had accomplished a "deanship" at Central High School in Charlotte where she was dean of girls. After their marriage they lived in Cleveland, Ohio. Dr. Berryhill was making \$2500 a year in 1930 as Chief Resident of Medicine at Lakeside Hospital. Mrs. Berryhill, a social worker, supervised delinquent girls there until shortly before their first daughter, Jane, was born.

Mrs. Berryhill's influence on her husband's career has been strong, but subtle. A little story Dr. Berryhill recalls shows how:

"The first year I was dean there was a terrific snowstorm. We lived down where Fowler's Food Store is now. About 7 a.m. I decided it was too bad to go out. I told Norma I wasn't going to go to class. She

told me that I must. 'Even if only five of the students are there, they came to learn medicine and they should be taught,' she said."

She bundled him up and sent him to school.

"I arrived late, but every damned man in the class was sitting there. That class was a joy to teach anyway, but after that day there was a rapport between me and those guys in the Class of '42 that I'll never forget."

Dr. Berryhill had already been touched by what he considered that class' sensitivity to his problems during his first year as dean. "They seemed to sense my insecurity and they tried to help every way they could."

It would seem likely that the insecurity he felt was not the result of personal self-doubts, but rather of his sense of responsibility to the University and Dr. Manning. He may not have been as concerned about being the best as he was about getting the best for the school.

Yet, if there were any areas of medical education he had not studied and analyzed, one cannot find it. When he returned to Chapel Hill to stay in 1933, he directed the Student Health Service, supervised the teaching of a course in physical diagnosis to second-year students, and maintained his own practice. During his student days he developed strong opinions about what made a good teacher and a good dean. He began immediately after his return, working to integrate clinical information into basic medical science courses. He was fascinated with the way a hospital works in conjunction with a medical school. And he was aware that, already, the two-year medical school was growing less popular with doctors and educators.

Dr. Berryhill is credited with being the one who found a way to gain acceptance for a four-year program, after 60 years of struggling. Dr. Womack recalls that success clearly:

"Other people had tried, but Reece was the one to hit upon a

secret weapon — the alumni. The country boys came through. He and some other dedicated people contacted alumni and friends of the University — and we had many — and asked for help.

"There were about six or seven years there when these people put in a tremendous amount of work, without publicity. They asked for help from anybody who believed in what we were trying to do.

"Not everyone thought that the state of North Carolina needed another four-year medical school, but Duke did not have a primary obligation to the people of this state. We did."

No one stresses the importance of the University's friends more than Dr. Berryhill. Dr. Womack recalls "brutal times" during that struggle, and "Daddy" Ross remembers years of "benign intrigue" which frustrated them all. But Dr. Berryhill's recollections center on comments about those who intervened at crucial times.

Other factors, too, played a vital part in getting a four-year program through. In 1944, the Broughton-Poe Commission recommended the expansion of the medical school, state aid for hospital construction, and the establishment of a Medical Care Commission.

During 1946, the Good Health Association was started. A native of the state, Kay Kyser, used the name he had gained with his radio show, "The Kollege of Musical Knowledge," as a way to help. He garnered the support of other famous celebrities from the state, who worked with a citizens' committee. They crusaded to create an awareness of the state's health needs. The campaign was a resounding success.

During this period Congress also passed the Hill-Burton act, which enabled local communities to obtain money for construction of hospitals. This, too, brought the health-care crusade home to Carolinians who lived many, many miles from hospitals.

A request for funds for the



four-year program was made in 1946. It was approved in 1947 by the Legislature. After some delays the money, \$5,290,000, became available in 1949. The appropriation was for North Carolina Memorial Hospital, an addition to the existing medical school building, the School of Nursing building, and residence halls for nurses as well as one for interns and residents.

The request was four years old by the time the money became available, and post-war inflation had shrunk the purchasing power of that money. But it was a beginning.

"We knew we'd make do with what we had," Dr. Berryhill says.

"After we got that first money, we knew we were on our way!" Dr. Womack says. "Right off, people wanted us to have one of the great medical schools of the country. North Carolinians are just like that about their schools. Worse than Texans. Anyhow, they had no idea of the national picture, what it cost to run a medical school. But they were willing to learn, and they did learn. Once we got started, the Legislature never disappointed us."

Money, however, does not mean there is a school, only that there is a place for one. Recruiting men to develop the clinical departments for teaching students and staffing the hospital was no easy task. Dr. Berryhill consulted Dr. Alan

Gregg, at that time director of the Rockefeller Foundation. Dr. Gregg, a Harvard man, advised Dr. Berryhill,

"The University of North Carolina is an old, highly regarded institution. Don't try to copy any other institution's medical school. This is often done. Make this medical school your own. Pick men who seem to fit into the development of the school, ones who care about it."

Those who were chosen came from some of the most prestigious medical schools in the country: Harvard, Yale, Columbia University College of Physicians and Surgeons, Jefferson Medical College, the University of Pennsylvania, Duke, and Washington University.

Dr. Womack, the first chairman of the Department of Surgery, said, "When we started we had the experience of different geographical locations, and a blend of the knowledge of what had worked in some of the best schools in the U.S.

"This created almost a national consensus of the experience in medical education. Suddenly, we weren't just a bunch of guys in a pine forest. What we had was working."

There were a lot of reasons why it worked.

"There was a different context," Dr. Berryhill said, "a different relationship between students and faculty. If a problem needed to be solved, you could call up five or six people you knew intimately, worked with every day. You all might argue a damned lot, but finally a reasonable agreement was reached — one everyone could live with. You could feel as though you were getting somewhere. That feeling is not as easily come by these days, when everything is bigger and more complicated."

In slower, easier times, Dean Reece Berryhill relied upon a devoted faculty and staff and yellow legal pads. Miss Sarah Virginia Dunlap, secretary, administrative assistant, and secretary of the faculty recalls: "We could never get him to take a vacation. The only place he'd

...was to the beach and then he'd
 take those yellow pads. Regular-
 ized ones wouldn't do — they had
 to be legal size. When he came back,
 the pads would be full."

It still bothers Miss Dunlap
 that she never persuaded him that the
 dictaphone was easier. "Maybe
 that's because he's not mechanical.
 But he preferred to write. How he
 wrote!

"Often when the girls (daughters
 Jane and Catherine) were away from
 home, he wrote them." When Mrs.
 Berryhill travels now, she asks him
 to write her letters before she goes,
 so she can get used to deciphering
 his exquisitely illegible handwriting.

Miss Dunlap also remembers
 that he was a great note writer.
 That spidery scrawl crept across
 many notes of comfort, encourage-
 ment, and congratulations. "He has
 an uncanny sense about people. He
 knows when they need to be en-
 couraged or when some flowers from
 his yard will make a bad day better,"
 she says.

While the young dean was care-
 fully clipping newspapers, keeping
 track of his friends and students, Mrs.
 Berryhill was working around the fact
 that the School of Medicine "didn't
 have straw to make bricks."

Mrs. Berryhill says little about
 what she did during his days as dean:
 "I kept busy washing and cleaning for
 my living," she says with a smile. But
 Miss Dunlap is only one of those who
 wistfully remembers that a smaller
 university means that, "everybody
 knew everybody else well. Of course,
 things had to change with size. But
 then, the faculty was small enough
 so that Mrs. Berryhill could show
 prospective faculty members the
 town. Once they decided to come, she
 helped them find houses."

Others recall that she was there
 when the moving van arrived, bringing
 a casserole for dinner. Perhaps Mrs.
 Berryhill was a frustrated librarian,
 but numerous faculty members re-
 call being sent books about Chapel
 Hill and the University before their



Mrs. Berryhill

*"How many sandwiches
 that woman gave the school,
 and how many hours,
 no one can know,"*

arrival. Once Mrs. Berryhill
 immediately introduced them to
 friends and faculty members. She
 started an organization for students'
 wives and house staff members' wives.
 Her idea was that meeting and talking
 about the problems and responsi-
 bilities of being doctors' wives was
 something they could share.

Her dedication to UNC has
 been compared to Dr. Berryhill's.
 "How many sandwiches that woman
 gave the school, and how many hours,
 no one can know," a friend said.
 "More important," another said, "she
 gave unceasingly of herself." Dr.
 Berryhill says simply, "She did more
 than anybody."

The Berryhills' always had stu-
 dents in their home, but Miss Dunlap
 is not sure that she was as popular.
 "How those students hated to see me
 coming!" Dr. Berryhill's course
 physical diagnosis means that he knew
 all of the second-year students. In the
 years before 1954 (when the first
 Doctor of Medicine degree was given)
 he had to review their records as they
 made application for transfer.

"If he saw something he didn't
 like in a student's record, I'd have to
 go get him and tell him the Dean wanted
 to see him. He put the fear of God
 into them, demanding that each one
 work to his potential. Perhaps the
 fear of God isn't exactly right. They
 wanted his approval. He was fair and
 he had great faith in them. I think
 they wanted to justify that."

He treated them as adults,
 with the respect they deserved. A
 dignified man, he is impossible to
 caricature. "They had a terrible time
 with him on Student-Faculty Day.
 There was nothing they could
 mimic," Miss Dunlap remembers.

If there is one saying that
 reminds friends of Dr. Berryhill,
 it is, "I don't want to tell you what
 do to, but . . ."

A former student of his says:
 "He always said that he didn't want
 to tell us what to do. Then he'd say,
 'but,' and map out a battle plan.

"Chapter and verse, he'd tell



*"We may be
the only people
who ever went to Rome
for the sole purpose
of picking up letters."*

you what to do, who to call to get help, and damned if he wouldn't sit down and write a note congratulating you for accomplishing it!"

And then, quietly: "There have been some important times in my career when I wanted to hear those words. All I had to do was pick up the telephone. It was so good to hear him say, 'Now, I don't want . . .'"

Last Thanksgiving Dr. Berryhill was operated on for a peptic ulcer. One of his former secretaries, Miss Helen Jane Wettach, says, "It was so strange for him to be ill. He's the first person there when someone is sick. I don't know how he finds out, but he does. Patients have absolute confidence in him and he always wants to see them in the hospital."

He has not changed much with time. Soon after surgery, he began slipping out of his room to visit friends who were also hospitalized. A couple of weeks later he attended a meeting of the Division of Education and Research in Community Medical Care, which he established and directed after he retired as dean.

Concerned, Glenn Wilson, the associate dean for that division, asked, "Does Dr. Newsome know you're here?"

"I forgot to tell him," Dr. Berryhill said, and lit a forbidden cigarette.

Now he is 72. There are other things he wants to do — aside from being allowed to continue smoking and sipping Scotch. He won't say what his projects are, but a stubborn jaw suggests that he will see them through.

Whatever he undertakes, it will likely be associated with the University. "I have never known anyone who loved the University of North Carolina more," Miss Dunlap says.

(His gratitude to the school dates back to the days when a student could attend, tuition free, if he gave two years to teaching in North Carolina upon graduation.)

And Dr. Berryhill may be one of the few men who loves home and North Carolina so much he never wants to leave. Mrs. Berryhill, an enthusiastic traveler, has despaired of interesting him in maps and schedules.

Once, when they were on a train going to Rome, she recalls, she decided he was too miserable to travel any more.

"I have never seen a more homesick man in my life, and I can remember how horrible it is to be homesick. I told him we could get off at the next stop and go back to Scotland. I knew he'd be more comfortable there.

"He kept saying we had to go to Rome. I insisted we didn't have to go anywhere. Finally, he said, 'We do have to go to Rome. We have to get the mail.'

"We may be the only people who ever went to Rome for the sole purpose of picking up letters."

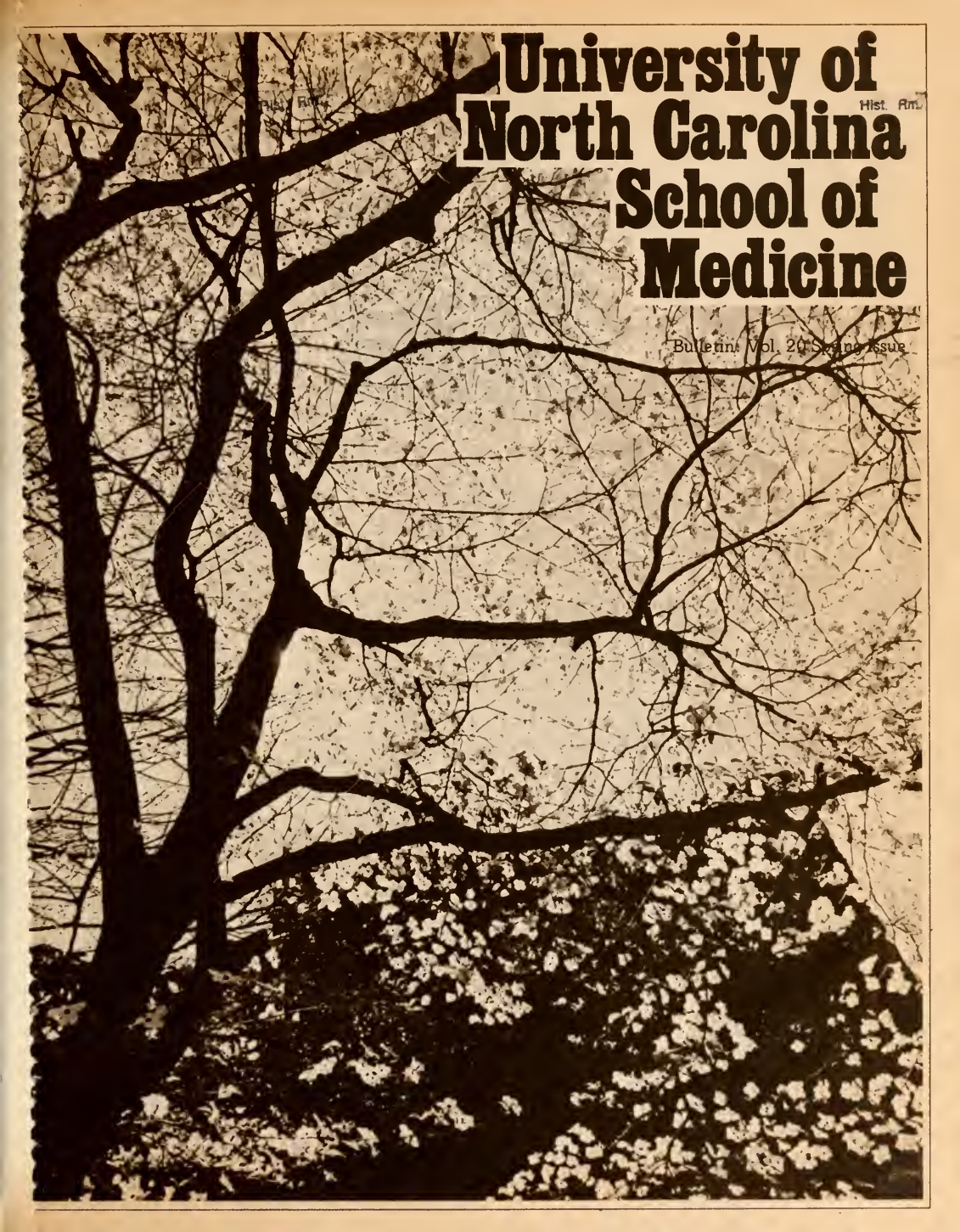
He calls her "independent" and says, "She always has been." She says of him, "He is the most modest man in the world."

Accomplishments, honors, and achievements can be listed. But that awesome list is only the skeletal outline of a strong spirit. It says nothing about a life built on love and loyalty and lived through principles and people.

Like a litany, the words, "I don't want to tell you what to do, but . . ." remain part of the way he performs his service to his students and friends. His strong heart and Scotch tenacity are sturdy reminders of what Carolinians came from. But better still, Dr. Reece Berryhill is an eloquent testimony to the best we can be.

UNC Medical Alumni Bulletin
226 MacNider
Chapel Hill, N.C. 27514

Rip here and let us hear from you.



University of North Carolina School of Medicine

Hist. Am.

Bulletin, Vol. 20, Spring Issue



The Bulletin's surgery was successful. Not many complaints. Only one, in fact. And many kind words. Too many, in fact, to suit the crustiest member of the Editorial Board. "The only places that don't get complaints are second-rate," he said. Since neither we nor he wish to be second-rate, your comments, criticisms and suggestions are eagerly welcomed.

This issue's publication was delayed by a frenetic schedule. First came Alumni Day, and 300 alumni and spouses made it to Chapel Hill. This was in spite of the gasoline shortage and an epidemic of streaking. Four alumni received DSA's and the class of 1954 rattled the chandelier in the North Parlor of the Inn. Quickly following was the Anglo-American conference on Continuing Medical Education.

Since this publication is funded by the Alumni Association, the board would like to thank Dr. Lewis Thorp. As president of the association in 1973, he managed to pop in and out of our offices regularly, despite an extremely busy practice in Rocky Mount. He offered leisurely consultations, as though he had nothing else to do. Dr. Thorp's great enthusiasm, easy-going ways and unflinching wit helped.

Again, there is a form for enclosing our news notes, or those you've collected about friends. Let us hear from you.



Bulletin Advisory Board

William Blythe, M.D.
John Herion, M.D.
John Sessions, M.D.
Raymond Wheeler, M.D.
Nathan Womack, M.D.
Oscar Sapp, III, M.D.

Chairman, Ex-Officio Member
Katherine Lewis
Editorial Associate

Cheree Briggs, Editor

Credits

Photographs by Maury Faggart
Design. Gibbs Associates, Inc.

Bulletin: Vol. 20 Spring Issue

University of North Carolina School of Medicine

Table of Contents

Relief now!	4
126 MacNider	10
HEW's chilling course	11
Of chalk, classrooms, and clinics	17
1974 Interns	18
Who's where	21
Four Alumni win DSA's	22
A very good year...	24
What is a good doctor?	25

The Bulletin, of which this publication is Volume 20, No. 2, is published quarterly by the UNC Medical Alumni Association, Chapel Hill, N.C., 27514. Postage is paid by the non-profit association through U.S. Postal Permit No. 24.





Relief Now!

by Harden Howell, '74

The combination of an interest in American Indians and a secret longing to be a cowboy prompted me to apply to a Public Health Service program. When accepted, I was appointed to the PHS Indian Hospital on the Fort Belknap Reservation near Harlem, Montana. I spent 12 weeks there this past summer, working in a 22-bed hospital that provides medical care for approximately 1,500 members of the Gros Ventre and Assiniboiné tribes. My experience was an education, perhaps culturally more than medically.

At the outset let me note, however, that my observations are those of a fourth-year medical student. Equally important, my conclusions are drawn from my experience on one reservation. I shall compare the Indians

with whom I worked when it is within my ability to do so. Otherwise, I do not intend to suggest any broad generalizations regarding American Indians, as my experience and knowledge is limited.

The summer experience actually produced several stories.

One story is Montana itself. They call it "Big Sky Country," and a single sunset tells you why. Never have I been anywhere that made me feel so free. The snow-capped mountains in the western part of the state are majestic. I could easily spend weeks in Glacier National Park, searching for big horned sheep along the high mountain trails. The central and eastern part of the state is part of the great plains. Its beauty takes time to appreciate. A

hurried glance will overlook the beauty of a barrel cactus in bloom. Impatience will destroy the chance to see pronghorn antelope in the coolees.

The people of Montana make up another story. Montana is the fourth largest state in the nation, with 147,138 square miles. The total population is only 694,409, less than the population of Washington, D.C.

But courtesy is the norm, not the exception. Your name is your word. I was never asked for proof of identification anywhere in the state. Garage mechanics insisted on providing transportation while they repaired your car. Bank tellers were surprised, and maybe a little insulted, when you asked for a receipt for a deposit to your checking account. In three months

I did not meet anyone who was too hurried to be pleasant.

The third story is really the first Montana story. It is about the Indians. A fourth story could be about the Indian Health Service. I intend to tell these last two stories, at least in part. The story is depressing. It has to be.

The hospital is a two-story brick building located on the Fort Belknap Agency grounds. The agency occupies the northwest corner of the Ft. Belknap Reservation, which is roughly a 25- by 40-mile rectangle on the high plains of north central Montana. Two or three hundred people live on the agency grounds in houses that have that government-built look. In addition, there are two small towns on the southern end of the reservation, in the shadow of a small range of mountains called the Little Rockies. The two towns are Hays and Lodgepole.

Any person who is five-sixteenths or more American Indian, regardless of tribe, can walk into the Ft. Belknap hospital at any time and receive free medical care. These services include examinations, out-patient treatment, inpatient care, emergency care, dental care, laboratory work including X-rays, and all drugs. Twenty-four-hour ambulance service is also provided. If an Indian lives within a certain geographical area, which includes but is larger than the reservation, his care is unlimited. We could refer him anywhere for any services which are not available locally. The government pays the entire bill, including transportation. Indians from outside the specified area are entitled only to services provided locally. Caucasians may receive only emergency care, for which they are billed the sum of \$3.75.

Other health-related services are provided by Community Health Representatives (CHR's). These are local

Indians who are employed by the Indian Health Service. They make home visits to the people living in their area. They also provide transportation for patients with no other means of coming to the hospital. In addition, the government sponsors many other health-related programs, including visits by an optometrist once or twice a year and prenatal counseling. Indeed, all elements for a totally comprehensive medical care delivery system exist -- at least on paper.

The absence of a crucial element in medical care delivery was obvious. Doctor-patient rapport not only did not exist, but probably is rendered impossible within the existing system. Now, don't misunderstand. The patients one sees in the daily clinic are generally polite. Whatever the M.D. says seems to be well-received most of the time. The Indians seldom ask questions. They rarely look the doctor straight in the eye. It is at night, when Indians are brought drunk to the ER after a fight that we heard what I believe to be the true sentiments of the Indians. To say that the Indians resent the white physician is an understatement.

Why should these Indians resent doctors? For one reason, they said we were young doctors sent out to practice on the Indian so that we would already have experience when we went back to take care of whites. They had a point. The assigned PHS medical staff consisted of one M.D. who had done a straight medical internship, one M.D. who had just completed a rotating internship, and a dentist who had just graduated. We also had a middle-aged internist who worked at Mt. Holyoke College in Massachusetts. He came out to work at Ft. Belknap for approximately three months. I rounded out the team.

As a group, we were weak in orthopedics, obstetrics, pediatrics, and surgery. This fact was unfortunate, since we did have to handle orthopedic problems frequently, delivered about ten babies each month, cared for kids of all ages, and sewed up bad lacerations, sometimes including tendons in the hand. I think we did offer good, up-to-date management of most internal medicine problems. Undoubtedly, our greatest contribution was in the area of infectious disease. We had fairly high-quality microbiology available at the hospital, including antibiotic sensitivities. And, we were not forced to treat without positive cultures. The CHR's could not only bring a patient back for treatment if a culture was positive; they could also go into a home and culture an entire family if indicated.

A few facts provide the final assessment of the Indians' charge that their doctors were not fully trained. Three PHS doctors left Ft. Belknap while I was there. All were headed for further residency training before going into private practice, presumably with a majority of white patients. The two replacements also said they planned to return to residency programs after finishing their tour of duty. The Indians were right. We were working on them without the background we would require prior to entering private practice in white, middle-class America.

The Massachusetts internist, competent in his field, was an exception to most assigned to the Indian Health Service through the PHS. In general, the government tries to get the cheapest doctors possible. These, of course, are doctors with the least training. Maybe it was possible to be competent in all of the major medical fields when one finished medical school and internship in past years. This is not the case today.

Medical education today is structured so that even a graduate with a rotating internship is not qualified to go right out into true general practice. On any teaching service, if complications arise the resident who is going to specialize in that area takes over, not the intern. Consequently, in my opinion, the minimum requirement for M.D.'s working at Ft. Belknap should be a completed family practice residency. Without the pressure of the draft, however, the PHS is not going to attract these M.D.'s.

The Indian Health Service is already having difficulty employing physicians. I noted above that three M.D.'s left while I was at Ft. Belknap. One had completed his two-year tour of duty. Two were resigning from the PHS after only one year. They were leaving for three reasons: they were tired of verbal abuse, they were fed up with trying to work with the IHS bureaucracy, and there was no draft to make Ft. Belknap the lesser of two evils. I also noted previously that only two replacements for the three departing doctors had been obtained when I left. Non-existence of the draft is largely responsible for this problem. If the draft stays out, the PHS will have to make many changes to attract sufficient numbers of M.D.'s. The IHS method of rotating doctors in and out every two years is not that good anyway. If ever there was a population requiring a long period of time to develop mutual trust and respect for a doctor, these Indians are it. The ideal doctor for them would be a well-trained one who would spend his entire medical career at Ft. Belknap. This will not happen under the present system even with pay increases. Given a choice, no physician is going to willfully stay in a system in which he can go to the pharmacy and find out that penicillin is out of

stock, despite the five forms he filled out in triplicate six weeks earlier requesting supplies.

The verbal abuse of doctors was a real problem. Each of us received his share. It is most frustrating to get up at 3 a.m. and listen to a drunk call you a damned white SOB while you try to sew up his lacerations. Frequently, they got so worked up that they decided to leave. Then we had to attempt to pacify them. Otherwise, they would return in several days and have to be admitted with a severe infection. I realize this scene occurs in many city hospital emergency rooms; however, physicians in these ER's are either compensated by being in a training program, or they are there by choice. I could understand the M.D.'s who could find no good reason to accept this abuse at Ft. Belknap.

The Indians seemed to accept no responsibility in the doctor-patient interaction. This was illustrated by those Indians who would remain silent, refusing to give a decent history. They would play dumb and claim not to know the answer to a question like "How many times have you vomited today?" Obviously the answer was known, at least in terms of "only once" or "many times." Their reaction seemed to say, "You're supposed to be the great white doctor. Here is my body. Fix it."

The Indians did have a definite idea of what they considered appropriate physician response. Part of this response was giving out drugs. The medicines were free, and the Indians considered it a violation of their rights if a doctor decided no drugs were indicated. It was this attitude that earned several drunk but otherwise healthy Indians an IM injection of thiamine before they were sent home.

Another unusual phenomenon was the lack of tolerance for pain which these Indians manifest. When they hurt, they demand relief NOW! It does not matter what the doctor is doing, or that the Indian suffered quietly for 45 minutes while riding to the hospital. In the waiting area outside any active ER, one can see patients who are actually in pain, but who wait quietly until they can be seen. Not these people. They would scream at the top of their lungs. The patient's family and friends would follow the doctor around demanding that he care for the patient at once - even when they could see he was busy with another sick patient. This aspect of M.D.-patient relations surprised me. Even the internist from Massachusetts, whose experience was much greater than mine, found this behavior most remarkable.

The fact that it was usually a drunk Indian who openly expressed feelings of resentment has already been noted. Unfortunately, we heard these sentiments frequently, as alcohol is the number one problem on the Fort Belknap reservation. IHS statistics bear this out. Most of the trauma we saw was directly related to alcohol. We always had several inpatients with probable alcoholic cirrhosis as the leading diagnosis. Both sexes and all ages were involved. Our youngest drunk was a 14-year-old boy who was brought in comatose. He had been found lying in the parking lot at 2 a.m. after a local pow-wow. Of course, no one knew anything about what he had taken. His blood alcohol was 290 mg%. The next day he admitted drinking a pint of mint gin alone.

One was forced to wonder why alcohol played such a prominent role in the life on this reservation. I think the answer is closely related to the resentment these people felt toward



as. At least part of this resentment was toward us as representatives of the white establishment, rather than as doctors. The basic problem is a sort of cultural shock.

Not so many years ago, in terms of cultural development, the Gros Ventre and Assiniboiné Indians were nomadic hunters on the high plains. They followed the buffalo back and forth across what is now the U.S.-Canadian border. They depended on the successful hunt for survival. Modern weapons were not available, and therefore the success of their endeavors depended on the combined efforts of all the able males in the tribe. Buffalo were chased over steep cliffs, falling to their deaths. Just as the work was shared, so were the products. When food was scarce, it was even more readily shared. The survival of the individual depended on the survival of the group.

A single good hunt could provide food for weeks or months. Leisure time was therefore abundant. Their lifestyle was aptly described by the old Indian who said to a white man, "You measure time. We enjoy it." During their leisure time, these Indians developed an elaborate pattern of religious ceremonies, most of which included dancing. In fact, almost every significant event that concerned the tribe or a member of the tribe called for a dance. The pow-wow today is a holdover from these ceremonies.

Another leisure time activity was an occasional raid on another tribe. This usually occurred when a tribe felt that another tribe was infringing on their territory, or when a rival tribe's movements appeared as a possible threat to the buffalo herd. Misinterpretation of intention was easy, since the tribe moved their camp about every four days from spring

through fall. I was very interested to learn that the Gros Ventre and Assiniboiné had once been enemies engaged in fighting each other. Even today, inter-tribal hostility exists. A geographic segregation exists on the reservation. The older Indians do not like inter-tribal marriages, and one told me that they rarely occur.

How, one might logically wonder, did these two enemy tribes end up living together? As with the rest of the American Indians, they were overwhelmed by Manifest Destiny. Uncle Sam took these wandering hunters from enemy tribes and said, "Now look, dammit, you're gonna be farmers and live together. And furthermore, you're going to like it!" So the Fort Belknap Reservation was created in 1889.

Initially, it was located north of the Milk River, about 10 miles west of its present location. Unfortunately, however, it turned out that wheat could actually be grown there. In response to white farmers and ranchers, the reservation was moved south of the Milk River to its present location where nothing grows without constant irrigation. The new reservation did include the beautiful Little Rockies. But, as luck would have it, gold was discovered in those mountains. As you have already guessed, this corner of the reservation was chopped off.

The result of the above is that two tribes with no agricultural expertise are trying to farm land that would give a county agricultural agent trouble. This is in addition to their natural animosity. The Bureau of Indian Affairs was charged with running things. BIA agents passed out food during winter months, advised on land use, etc. Documentation of the BIA agents' dishonesty and mistreatment of the Indians is easily obtainable. Just ask an Indian. Should

you desire more objective evidence, refer to Pioneer Cattlemen in Montana by Walt Coburn, a white rancher who grew up on the Circle C Ranch adjacent to the Fort Belknap Reservation.

In addition to managing reservation affairs, the BIA was charged with wiping out the Indian culture. They established a school in agency buildings that still stand. Each fall, Indian children were taken to the school. They were not seen by their families until the following spring. Bertha Snow, a delightful lady who runs the sterile supply service at the Fort Belknap Hospital, related to me that her father had attended the BIA school. His hatred of the BIA had been surprising, even to his own children. He told Bertha of being whipped for speaking his native language. He had also had a brother who died during a winter at school. His parents were not even notified. Rather, when they came in the spring with food and treats for their children, they were simply told that the child was dead, buried without their knowledge.

In all fairness, I shall have to admit that the BIA was very successful. Most of the Indian culture has been wiped out on the Fort Belknap Reservation. The Gros Ventre language is entirely forgotten. Only a few older Indians can still speak Assiniboiné. Perhaps the only young Indian on the reservation who actively tries to preserve the Indian culture is Harris Rock. Harris is in his thirties. He is the father of ten and is currently completing training as a registered nurse. In 1959, Harris was the International Ceremonial Indian Dance Champion. He speaks fluent Assiniboiné, and can spend hours describing Indian ways. He explained to me how everything had meaning for the Indian. Tepees were to be set up in a specified manner,

with the door facing East. Each ornament on a ceremonial dance costume had a certain significance. A feather in the hair meant the Indian had killed a man. Each movement in a dance had meaning. The braves told stories of their adventures through their dance.

Harris was greatly disappointed in the apparent lack of interest in their cultural heritage which Indians at Fort Belknap display. When pow-wows took place, many Indians - both young and old - dressed up and participated in the dancing. Harris had very old, authentic costumes. Most others wore anything they could find. Harris once remarked that there were some very brave girls around - they wore feathers indicating that they had killed men. To me the dances looked authentic, but Harris said they might as well have been doing the Watusi. The older Indians said that the young Indians told bad stories.

The cultural heritage of the Gros Ventre and Assiniboiné Indians, the social framework which defined the behavior from which their self-respect was derived, has been stripped from them. Their values have been defined as inappropriate in the world of western man. Compulsiveness, so necessary for successful farming, is not a trait to be derived from the heritage of nomadic hunters.

The consequences: a society in which alcoholism takes an excessive toll. Unemployment is high. Those

who do work have limited options. Some government jobs exist. The BIA hires several Indians. It also works with the tribal council to operate federally funded programs which provide jobs. Many Indians work in health-related fields. The hospital employs 55 Indians. Other Indians work for neighboring ranches. A small number operate their own ranches, raising beef cattle and wheat.

The price of success is high for an Indian. To become goal-oriented and compulsive enough to advance to a position of responsibility in a society dominated by white values is to reject Indian values. In reality, the price is a degree of ostracism. The director of the Fort Belknap Hospital is Indian. His appointment represented a laudable first on the part of the IHS, I think. I was surprised when some young Indians described the director as an "apple Indian." Questioning revealed their meaning, red on the outside but white on the inside.

The home life of these people is fragmented. A majority of girls have had at least one illegitimate child before the age of 20. This does not affect their ability to attract husbands later, but it does result in many children - being brought up by grandparents, other relatives, or even friends. Defining those with direct parental responsibility for a given child can be a real task. The institution of marriage itself is of questionable stability. The number of illicit affairs was remarkable for such a small population. We were directly faced with this fact, as marital troubles precipitated much of the trauma which kept us up at night.

These Indians do not necessarily have to have white man's legal approval for a marriage. This is more true among the older and middle-aged Indians than it is among the young. And it is fine, until you have to start trying

to fill out some government form. More than once I became frustrated when the current husband turned out not to be the legal husband, and no one was sure of the appropriate legal surname. Once as I was filling out commitment papers for a patient who was unable to communicate due to an organic brain syndrome, I came across two different names in her records. I questioned her family as to the patient's correct name, and they came up with a third name from a marriage they were not sure had ever been legalized. I finally decided to ignore this third name and hoped that no trouble would arise from my decision.

An aura of hopelessness pervades the reservation. Efforts by tribal leaders to initiate programs beneficial to the tribe are usually poorly planned and short lived. Even the youth seem to be locked into the system. Many of them attend special Indian boarding schools during the high school years. Quite a few go on to college, usually to train as teachers. The government pays the total cost for their higher education. On questioning, the BIA agent who oversees the Fort Belknap college students told me that only one Indian from the reservation had ever entered law school, and no one had ever gone into medicine, nor even expressed an interest in doing so within his memory.

Following education, many young Indians return to the reservation. That is where other Indians live. That is where their land is tax free. That is where their medical care is free. That is where the conflict between their basic Indian instincts and white western society is minimal. The reservation provides a thin buffer zone to shelter the Indian. It does not offer an environment conducive to the assimilation of the Indian into western society in a total sense, if indeed this

is even desirable.

The point is illustrated by the 26-year-old Indian male who came in for a college physical one afternoon. I inquired as to his field of study and learned that he was studying to be a certified public accountant. He then looked away and said in low tones that he doubted that he would ever use his education. His reason was that he wanted to return to Hays to live. I had to agree with him. I doubt if the one general store in Hays could support a CPA, and the nearest larger town was miles away.

I have referred to the pow-wow several times. Since the pow-wow is the most visible surviving element of the Indian tradition, it perhaps deserves a more detailed description. A pow-wow consists of a gathering of Indians for a weekend of dancing. Most Indian communities have dance grounds. A narrow, circular wooden frame is constructed around the open dance area. When pow-wow time comes, green branches are cut and laid over the frame. On the day before a pow-wow, Indians begin arriving from all over. Many come from Canada. Others are from tribes living throughout the U.S. The visiting Indians as well as local Indians camp at the pow-wow grounds, setting up teepees or other tents. Local ranchers donate beef, and rations are provided free to all who come and camp.

Pow-wows operate on Indian

time; that is, whenever the spirit moves whoever has to be moved to get things going. We once made the mistake of arriving on time to see dances scheduled to start at 3 p.m. They finally got around to starting about 9:30 p.m. No one was upset or irritated. This disregard for punctuality gave my type-A personality fits, but with luck, some of their easy-going ways rubbed off on me. As a matter of fact, I did not see an ulcer all summer.

Anyway, pow-wows begin with a parade, usually a few pickup trucks carrying some costumed Indians around the camp ground a few times. Then, the give-aways started. A give-away is one of the older Indian customs. As I understand it, a family who loses a member by death will decide to hold a give-away at the next annual local pow-wow to honor the deceased. The family so notifies the pow-wow committee. Then, at the appointed time during the pow-wow, the family is called forward. They begin by marching around the dance area in ceremonial fashion, with the oldest males leading. Next an announcer starts calling the names of local people to whom the family wishes to give a gift. Each person called goes forward to receive his gift. Gifts consist of blankets, ceremonial ornaments such as head-dresses, clothes, leather goods, and cash. The entire family, all the way to distant cousins, contribute to the cost of the give-away. Those who receive gifts are usually family friends, especially those who helped the family at the time of the honored member's death. Pow-wow organizers and singing groups also receive gifts, usually money. A single give-away may last an hour, and several hundred dollars worth of gifts may be distributed. Of course, the extravagance of the give-away is directly related to

the prestige of the family in the community.

After the give-aways, the dances eventually begin. Usually there are dance contests for girls, boys, men, and women. Winners get cash prizes. In between and after the contests there is general dancing with anyone participating who wants to do so. The costumes are all colorful. The sounds of the singing groups and their rhythmic drums together with the costumed dancers make the experience impressive.

Initially a pow-wow seems like it should be a tourist attraction, especially when a rodeo is added. This impression is wrong, at least with regard to white tourists. The only whites present were the few of us from the hospital who went to observe. Believe me, we felt conspicuous.

The last interesting phenomenon which deserves mention is the treaty payments. It seems that when a tribe produces proof of a treaty with the U.S. government which has been broken (which is not hard to do), the tribe can arrange a monetary settlement. While we were at Fort Belknap, the Assiniboines received such a treaty payment. Each member listed on the tribal roles received a check for \$990.00. Some large families took home around \$10,000.00. The result of this sudden influx of cash was wondrous to behold. By the end of the week I think we could have sewn up scalp lacerations blindfolded. Every bar within 100 miles must have benefitted from the treaty money. I remember one fellow whom we admitted primarily because he was down to \$300 two days after the payment. He said his "friends" would drink that up if we sent him out.

Lots of used cars found new homes on the reservation following

the treaty payment. This, however, did not compare to the small motor-bikes. I think every Assiniboine kid over age 4 had one. Families bought four at a time. Initially these motor-bikes caused no problems. It took a week or so for the young riders to gain confidence. Then we began to see at least one bike injury each day. There was no end to their imagination. They ran into trees, houses, cars, and each other. The bravest people were easily identified; they were the ones walking the agency streets.

This narrative may have led you to conclude that the only good Assiniboine is an "apple Assiniboine" but perhaps Bertha Snow can best explain what went wrong for them there.

A cultural workshop was held at Fort Belknap the last weekend that we were there. It was put on by a white man who had a large collection of Indian relics. The following Monday, Bertha asked me how I enjoyed the workshop. I commented that it was most interesting, but that I was surprised at how few Indians had come. It was then that she began an hour of anger and tears as she told why the Indians no longer cared. Her first statement was, "The Indian was once proud. But now, he don't care if you stand in front of him, behind him, or on top of him."

We hope that in time he will again care.

It has been a most difficult, in some ways very exciting year and somehow I believe that this issue of *The Bulletin* is a propitious time to say a few words of thanks:

To the faculty of the School of medicine for distinguished service; for genuine leadership in educational, patient care, and research programs; for competing effectively for support at the national level - - and for a remarkably good spirit withal.

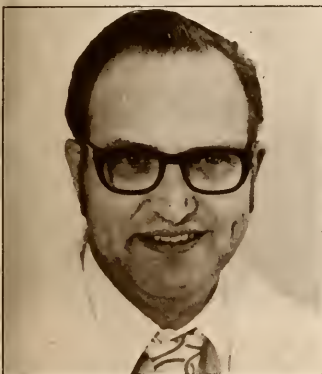
To the student body for support, advice, and participation; and for strong performance and future promise.

To the supporting staff for helping keep the ship afloat.

And,

To Mr. Danielson and his staff for making the NCMH a better place, and for developing one of the most effective working relationships between a medical faculty and a major teaching hospital extant anywhere.

To Associate Dean Wilson, his staff, the clinical departments, the other health science schools, and our colleagues throughout the state for developing one of the most promising approaches (AHEC) to achieving in North Carolina: a better supply of physicians and other health workers, and a better distribution geo-



graphically and by specialty among other things.

To the General Assembly, for funding the program.

To Associate Dean Cromartie for his devoted and statesmanlike leadership in helping us provide as much support as possible to the Greenville program.

To the departmental chairmen for their remarkable capacity to wear institutional hats when necessary, and for their outstanding leadership in a most trying period.

To all my colleagues in the Dean's Office for their unswerving devotion and effective efforts in behalf of the School.

To Dr. Lewis Thorp and Dr. Oscar Kapp as immediate past president of the Alumni Association and Associate Dean, respectively, for their leadership during the past year.

And to the Alumni, whose growing support in many ways is a vital element in the School's future.

HEW's Chilling Course

by William B. Blythe, M.D.

Editor's Note: Dr. Blythe, '51, is Director of the Clinical Research Unit of The North Carolina Memorial Hospital. Opened in 1962, clinical investigators who receive permission may do research involving human subjects in the CRU which has the most highly sophisticated equipment in the medical center. Approximately 850 patients participate in programs each year, with their consent.

The author, a certified liberal, expects fire from all sides as a result of this article.

Some weeks ago, I agreed to write about the plight of investigation involving human beings. At the time I was angry and somewhat discouraged, not only by what was happening to clinical research, but by what I thought might very well affect the clinical practice of medicine.

The reason for my ire was the latest in a series of policy statements concerning the use of human subjects in research. This was issued by the Department of Health, Education, and Welfare (HEW).

I, and others, found parts of the policy to be excessive and totally impractical.

The issue is not whether human beings should be employed in research. I think that they should be. Nor, at issue, is the question of whether a policy that protects the rights and welfare of research subjects should be established. I emphatically believe that it is imperative that one is established.

To my knowledge, no one has written about the issue as I see it: how an effective policy in this area can be established without niggling bureaucratic detail - detail which tends to

hide the reasons for which policy is established.

One might call this article, "The Natural History of a Policy, Government Style." I should like to trace the history of the involvement by the HEW in the protection of people who are the subjects of experimentation so that you may see for yourself the ways in which this policy grew and, in my judgement, eventually became "deformed." Few of us can spare time to read these long, dryly worded documents. I have pared these so that you may determine whether you agree that the situation is as serious as it seems to me.

The search for a reasonable policy began by assigning responsibility for review to the institution receiving the grant, assuring that the patients, the methods and the risks involved had been carefully weighed and judged acceptable.

Many memos later, the policy is set on a chilling course. The Secretary of HEW added an "enforcement clause." That is, if an institution is judged to have made a mistake by HEW, the Secretary may prevent it from receiving FUTURE funding, no

matter how worthy the research.

But let us go back to the beginning. The story starts, and is inextricably intertwined with, the explosive increase in biomedical research which began in the late 40's and continued into the mid-60's. During this 25 or so years, it was our happy privilege to observe, participate in, and partake of the fruits of one of -- if not -- the most productive and heady eras in the history of medical science. Clinical investigation, along with the other forms of research, flourished.

However, many people -- theologians, philosophers, consumer advocates, lawyers, and, most notably, clinical investigators themselves -- were deeply troubled by a lack of standards for the ethical aspect of investigation involving human subjects. Numerous stories came to light in which it was plain that the investigator's zeal to get to the root of a problem clearly exceeded his concern for the rights and welfare of his fellows who were the subjects of his research.

Thus, a decade ago, the Public Health Service began a study of the "moral and ethical aspects of clinical investigations" that were supported by grants from the Public Health Service. The report of the study was made in 1964 and included the following statements which are germane:

"Progressive changes in the kinds of clinical research possible to undertake are changing the nature of risks and values relating to clinical research."

"There is no generally accepted professional code relating to the conduct of clinical research."

"The legal status of clinical research is ambiguous."

"There exist conspicuous differences in institutional attitudes



toward acceptable professional conduct of clinical research."

"As the number of investigators, subjects, and institutions engaged in clinical research increases and as the nature of the risks ventured changes according to the extension of research into new areas, a mounting concern is expressed over the possible repercussions of untoward events which are increasingly likely to occur and which may occur in an unfavorable pattern of context."

Although the language is that of the bureaucrat, it is clear enough to recognize that problems existed in terms of definition of the ethical and legal aspects of clinical research. As a result of the report, two actions were taken: (1) The Public Health Service began identifying for special consideration those research grant proposals which involved human subjects; and (2) the report was considered by the National Advisory Health Council.

In December, 1965, the Council adopted a resolution which re-

commended that institutional group review of projects involving human subjects be undertaken to assure "an independent determination of the protection of the rights and welfare of the individual or individuals involved, of the appropriateness of the methods used to secure informed consent, and of the risks and potential medical benefits of the investigation."

The Surgeon General of the Public Health Service accepted the resolution of the National Advisory Health Council and promulgated the following policy statement in February, 1966.

"No new, renewal, or continuation research or research training grant in support of clinical research and investigation involving human beings shall be awarded by the Public Health Service unless the grantee institution will provide prior review of the judgement of the principal investigator or program director by a committee of his institutional associates. This review should assure an

The Clinical Research Advisory Committee, in turn, devised a system of review which emphasized the responsibility of the investigator and his department chairman, as well as the Committee itself, in the review process in an effort to create a climate in which faculty members themselves set high ethical standards in performing clinical investigations. It decidedly avoided a police system wherein the Committee would serve as official snoopers who stalked the wards and laboratories in order to apprehend those who violated the letter of the "law."

This approach was based on the conviction that the overwhelming preponderance of investigators were honorable men who would seek the advice and guidance of a committee of peers in questionable matters concerning the use of human subjects. And those who would not would be ostracized from the research community.

This approach was perfectly consistent with the policy statement. Notice that the statement simply says that "the grantee institution will provide prior review of the *judgement* of the principal investigator or program director by a committee of his *institutional* associates . . . and that this review "should assure an independent determination:(1)of the *rights and welfare* of the individual or individuals involved, (2) of the *appropriateness* of the methods used to secure *informed consent*, and (3) of the *risks and potential medical benefits* of the investigation." The statement pointedly does not specify the exact composition of the review committee, although it does say that the committee shall consist of his institutional associates. Furthermore, the statement neither supplies nor insists that the grantee institution supply exact definitions of appropriateness, informed consent, risks, and medical benefits. Lastly, the

statement indicates that this local review should be undertaken before the investigation is actually commenced and not before a grant request is submitted to an agency of the Public Health Service. The complete statement in other parts went on to say that once the Public Health Service approved of an institution's assurance that it agreed with these general principles and had a workable review process, an investigator in submitting a grant application simply had to designate the date of the assurance approval by the Public Health Service.

Here then is an example of federal interest, responsibility, and direction at its best. The Public Health Service left no room for doubt that it was profoundly interested in the protection of human subjects of clinical investigation from wrongdoing by unethical or misguided investigators; it made equally clear that it had faith in the integrity and collective wisdom of the local faculties in the institutions in which clinical research was being performed. Here was effective federal

independent determination: (1) of the rights and welfare of the individual or individuals involved, (2) of the appropriateness of the methods used to secure informed consent, and (3) of the risks and potential medical benefits of the investigation. A description of the committee of the associates who will provide the review shall be included in the application."

This statement was recognized as being necessary and reasonable by reasonable investigators. The University of North Carolina School of Medicine responded promptly to the Surgeon General's statement. A prompt response was possible because the Clinical Research Unit Advisory Committee, formed six years previously, had been established to perform exactly the functions outlined in the Surgeon General's statement for subjects being studied on the Clinical Research Unit. Dean Isaac Taylor simply enlarged the scope of the Committee to include the review of clinical research being performed in the Medical Center as well as the Clinical Research Unit.

interest and regulation without nagging and ineffective bureaucratic control.

Alas, this position was short-lived! In 1969 the Public Health Service re-issued its policy in an expanded format "in an effort to give the policy more substance without hampering the independence of the institutions, both grantee and contractor." In essence, the change in policy consisted of the phrase . . . "the institution must also certify to the Public Health Service for each proposal involving human subjects that its committee has reviewed and approved the proposed research *before an award may be made.*" Remember that the original policy stated that review must occur before that research was actually started. Awarding of a grant by an agency of the Public Health Service was not contingent upon local review and approval. Superficially, this change in policy does not appear to represent much difference; yet there are both philosophical and practical implications. Philosophically, it implies that either the Public Health Service is not certain that local review will occur unless money is withheld or that the judgement of the local reviewers must be overseen by the federal establishment. The practical consequence of the policy is that in many - if not most - cases two reviews must be made: one at the time the grant application is submitted and another before the research is begun, with the first review necessarily being superficial and perfunctory. This is true for several reasons. First, most grant applications are for three to five years and thus an investigator may not be able to precisely define what experiments he plans for the late period of the application. Oftentimes animal experiments precede the human investigations and their tack depends upon the results of the animal experiments. Secondly,

in the case of training grants, it may be impossible to clearly delineate the nature of clinical research to be performed by research fellows who have not been appointed at the time of the grant application. Thus, the initial review must be tentative, if it is to be an honest and thoughtful one.

Another emphasis of the expanded policy was the increasing specificity of the definition of "rights and welfare", "informed consent", "risks versus benefits", and the structure of review committees.

The effect of both these changes, that is, the requirement that review must occur before a grant is awarded and the more specific definitions, was to increase the ease with which control could be exercised from Washington and to diminish latitude and responsibility at the level of the medical schools and other local institutions.

Two years passed. On April 14, 1971, a directive was sent out from the Director of the Division of Research Grants, National Institutes of Health which stated that, as of that date, the acceptability of the proposal in terms of institutional commitments and regulations, applicable law, standards of professional conduct and practice, and community attitudes. The Committee may therefore need to include persons whose primary concerns lie in these areas rather than in the conduct of research, development, and service programs of the types supported by the Department of Health, Education, and Welfare." Furthermore, the directive stated that if investigation

of new drugs which involved human Public Health Service policy was superseded by a *Department of Health, Education, and Welfare* policy. This further expansion of policy provided two essential changes: first, the guidelines now applied not only to the Public Health Service but to all agencies of the Department of Health, Education, and Welfare, including the Office of Education, the Social and Rehabilitation Service, and the Social Security Administration; second, and more importantly, further definition and rigidification of the composition of review committees, the process of review, and informed consent and enforcement were established.

Several examples are illuminating. Whereas before, it was necessary only to describe the composition of the review committee it now became mandatory that, "Committee members shall be identified by name, occupation or position, and by other pertinent indications of experience and competence in areas pertinent to the areas of review such as earned degrees, board certifications, licensures, memberships, etc. . . ." and . . . "In addition to possessing the professional competence to review specific activities, the Committee should be able to determine subjects was to be undertaken in an institution, the Food and Drug Administration regulations must be adhered to, and this meant that the composition of the institution's review committee was further specified that the "committee must include no less than two competent and knowledgeable members who are licensed to practice the healing arts, and no less than one member not licensed in the healing arts, but competent and knowledgeable in other areas necessary to assure complete and adequate review of projects and activities commonly conducted by the

institution.

As for the review procedure itself, further proscriptions were set out which were really not different in substance from the previous policy but which necessitated considerably more paperwork.

Informed consent now became more precisely defined even to the point of stating that it consists of six basic elements, all of which were precisely delineated. Three types of forms that were acceptable to the Department of Health, Education, and Welfare were prescribed.

Lastly, for the first time, a section on enforcement of the policy appeared. In essence, this section states that the Secretary of Health, Education, and Welfare may, after receiving advice from reviewers, evaluators, consultants, and staff of the Department, may terminate a grant or contract. Furthermore, if, "in the judgement of the Secretary, an institution fails to discharge its responsibilities for the protection of the rights and welfare of the individuals in its care, whether or not HEW funds are involved, *he may question whether the institution and the individuals concerned should remain eligible to receive future HEW funds for activities involving human subjects.*"

The next action occurred in October, 1973, when the HEW published its proposed policy in the Federal Register. This maneuver is the first step in the conversion of policy of an agency of the Executive Branch to a rule, which has the force of law. The procedure is as follows. "If the Congress passes a new law, or if the Executive Branch finds it necessary to reinterpret, or to issue new policy, or if a law is changed by judicial interpretation, we issue what is called a proposed rule-making - - draft version of the new regulations. This proposed

rule-making appears in the Federal Register, a preamble . . . states the principle features of the new rule." Comment is invited, and following receipt of the comments the draft is revised "to obtain a consensus compatible with the terms of any legislative or legal requirements and compatible with the public interest." The result is then issued as a final rule, which has the force of law.

The effect of this action was undoubtedly the most far-reaching to this point. Not only was the existing policy given the force of law, but the policy was modified in the rule-making statement in such a fashion as to rigidify even further the review process. Particularly important is the emphasis on monitoring - of policing - of research activity. It is axiomatic that this monitoring will require huge increases in the commitments of institutions to provide many more people to do the monitoring and more space in which they shall work. More importantly, the idea of having a police force within its ranks is anathema to a community of scholars.

One month after its first tract was published in the Federal Register, the HEW issued in the Federal Register a "draft" of the recommendations of a study group concerned with policies and procedures for the "protection of children, prisoners, and the institutionalized mentally infirm in research, development, and demonstration activities." Space does not allow me to delineate the specific proposals in this latest statement. There is general

agreement among those who have studied them that they are, in places, much too proscriptive. It is, in my view, not reckless to judge that if this latest set of regulations are given the force of law clinical research with these groups mentioned will soon cease.

This, in sketchy fashion, is the story. Why is the denouement the way it is and is there a moral? Given my present pessimistic frame of mind, I must say that I do not have an answer to either question. Not being a political scientist, I do not understand all the mechanisms involved in the conversion of a necessary, just, and workable policy into a set of bureaucratic rules which, in varying degrees, subvert the initial policy. Although I do not know the etiology and understand the pathogenesis, I do recognize that disease is present, the consequence of which is the stifling of legitimate and potentially important clinical research. Unless we can reverse the current trend and return to a system that is based on mutual trust among the public, the government, and the research community, I believe that clinical investigation will wither away.

And, in case there are readers who see no danger or threat in what has happened to clinical investigation, I say that the clinical practice of medicine is likely to be a forthcoming chapter in the longer story.

This is the second of a series of articles by faculty and alumni. It is hoped these experiences will lead to a vigorous exchange of ideas about health care in North Carolina. The views of the writers will not necessarily reflect those of the UNC School of Medicine.



Since more than 125 full-time faculty members work in trailers or rented space, Dr. P. G. Arnold, a senior resident in General Surgery, decided every square inch counts. He has magically transformed what was once a telephone booth into his "office." The good doctor's headquarters (measuring 23" x 16") seem almost spacious. That's because he uses Deficit Red in the wall-to-wall carpeting and on the walls. The ruffles protecting his secret supplies and precious documents from prying eyes are in a cheerful color, Red Ink. A security system (the padlock) means that only Dr. Arnold has access to the suite. Dean Christopher C. Fordham, III, while noting Dr. Arnold is demonstrating the Scotch thrift characteristic of many Carolinians, declined comment on how such a young doctor gets by having these plush surroundings in view of the hardships of others.

Of chalk, and clinics

John B. Graham, Alumni Distinguished Professor of Pathology, has been named recipient of a \$1,540,003 research grant for the study of hematosi. Awarded by the National Heart and Lung Institute, the funds will support the work of five research groups for five years. The participating scientists, all from the Departments of Pathology and Medicine, are Emily Barrow, Frederic Dalldorf, Richard P. McDonagh, Robert H. Wagner, Herbert Cooper, Kenneth Brinkhous, Harold Roberts, William Yount, and Tom Griggs.

H. Robert Brashear, Professor of Orthopaedic Surgery, has been elected to the American Board of Orthopaedic Surgery. He is the second North Carolinian named to the twelve-member Board, which has set standards for board certification since its inception in Chicago in 1934.

Geoffrey Haughton, Professor in the Department of Bacteriology and Immunology, is principal investigator and member of a group awarded a project grant in the amount of \$941,404 by the National Cancer Institute. During the three-year period covered by the grant, Dr. Haughton will conduct four research projects to study breast, prostate and lung cancer in humans and Rous sarcoma virus in mice.

classrooms,

The American Cancer Society has awarded a \$6,000 Junior Faculty Clinical Fellowship for 1974-75 to Charles Herbst, Assistant Professor in the Department of Surgery. A general surgeon with particular interest in gastrointestinal physiology, Dr. Herbst's investigative work centers about the role of gastrin in diseases of the upper gastrointestinal tract.

Colin G. Thomas, Jr., Chairman, Department of Surgery, was a distinguished guest speaker at the Annual Meeting of the Kentucky Chapter, American College of Surgeons. Dr. Thomas's three papers — "Management of the Thyroid Nodule", "Changing Concepts in the Treatment of Parathyroid Disorders" and "Intestinal Obstruction in the Newborn" — highlighted the February 28, March 1 - 2 session.

Two alumni and two faculty members have been elected to Alpha Omega Alpha Honor Medical Society. William Easterling, Jr., Associate Professor, Department of Obstetrics and Gynecology, was chosen in 1974. In 1973, Harold Godwin, Fayetteville; Reginald Tucker, Henderson; and Christopher C. Fordham III, Dean, UNC School of Medicine were initiated.

Frank C. Wilson, Jr., Chief of the Division of Orthopaedic Surgery, has been appointed by the American Academy of Orthopaedic Surgeons to represent that body on the Council of Academic Societies of the American Association of Medical Colleges. The

Council, composed of two representatives from each of the medical and surgical specialties, is influential in helping determine the course of academic medicine in America.

Tom Griggs, a cardiologist in the Department of Medicine, was presented the Chapel Hill Junior Chamber of Commerce Community Service Award on March 1 for his work with the South Orange Rescue Squad.

Donald Dunphy has been appointed Coordinator for the Area Health Education Centers in the Department of Pediatrics. Dr. Dunphy was formerly Professor and Chairman of the Department of Pediatrics at the University of Iowa.

A dedication service for the Louis G. Welt Fellowship in the Department of Medicine was held March 30 at 10 a.m. in the Clinic Auditorium. Participants were five faculty members: Morris Lipton, Carl Gottschalk, Hal Fallon, Floyd Denny and Phillip Manire.

Dr. Robert Ney, Chairman of the Department of Medicine, announced the fellowship, established in honor of Dr. Welt after his death in New Haven earlier this year.

Contributions may be sent to the Department of Medicine, UNC School of Medicine, Chapel Hill, N. C. 27514.

Carl Gottschalk, professor of medicine and physiology, was guest editor of "Kidney International" in honor of Dr. Jean Redmon Oliver.

The UNC School of Medicine is one of eight medical schools in the U.S. and Canada selected for the Robert Woods Johnson Clinical Scholars' Program. The director of the program, David McKay is an assistant professor of family medicine. He participated in a pilot Scholars' program at Western Reserve before coming to UNC. The School will receive \$727,000 for 1974-1977 for a total of 18 scholars. The purpose of the program is to develop doctors skilled in finding better ways to de-

liver health services, particularly in primary care. The program offers great flexibility for each Scholar, who must continue his clinical specialty residency simultaneously with a project. Each Scholar designs his own, researching an aspect of the economics, epidemiology or management of medical care.

Bill Harris

Bill Glenn Harris, 43, Assistant Dean for Administration of the UNC School of Medicine and Assistant Director of the North Carolina Memorial Hospital, died in December.

A native of Engelhard, North Carolina, Mr. Harris had been associated with the School of Medicine since 1964. He served as Division Manager of the Thoracic Surgery Laboratory and as Business Officer of the Department of Surgery before his appointment as Assistant to the Dean of the School of Medicine in 1969.

He was best known for his work in medical electronics and computer technology, the area in which his teaching and publishing activities were concentrated.

He was Business Officers' Secretary of the American Association of Medical Colleges and was a member of Sertoma International.

His wife, Auburn Bland Harris, and his two children survive.

1974 Internships

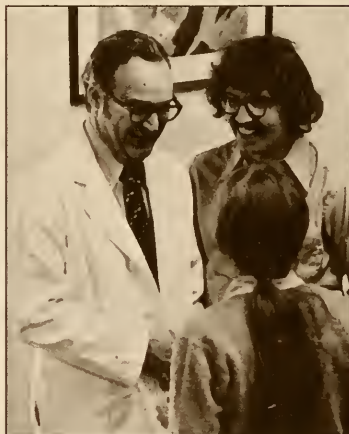
Robert Martin Alsop
University of Virginia Hospital
Charlottesville, Virginia
Surgery

John Harrison Baker
North Carolina Memorial Hospital
Chapel Hill, North Carolina
Ob-Gyn

Carl Alan Baum
Latter Day Saints Hospital
Salt Lake City, Utah
Rotating

Charles Britton Beasley
North Carolina Memorial Hospital
Chapel Hill, North Carolina
Surgery

Edward Perry Benbow, III
Letterman General Army Hospital
San Francisco, California
Medicine



Thomas Welborn Bouldin
North Carolina Memorial Hospital
Chapel Hill, North Carolina
Pathology

William Griffith Bowen
Barnes Hospital Group
St. Louis, Missouri
Medicine

William Edmund Bowman, Jr.
Letterman General Army Hospital
San Francisco, California
Surgery

Douglas Card Brewer
Wilford Hall USAF Medical Center
Lackland Air Force Base
San Antonio, Texas
Medicine

Michael Nelson Brothers
University of Colorado Affiliated Hospital
Denver, Colorado
Surgery

Donald Claude Brown
University of Oregon Medical Center
Portland, Oregon
Rotating

Paul Samuel Camnitz
North Carolina Memorial Hospital
Chapel Hill, North Carolina
Surgery

David Robert Clemmons
Massachusetts General Hospital
Boston, Massachusetts
Medicine

George Watts Colclough
New Hanover Memorial Hospital
Wilmington, North Carolina
Rotating

Charles David Collins
University of California Hospital
Los Angeles, California
Surgery Residency

John Frederick Colpitts
Madigan General Army Hospital
Seattle, Washington
Family Practice

David Leon Coppedge
University of Chicago Clinics
Chicago, Illinois
Ob-Gyn

William Foscue Cox, Jr.
University of Colorado Affiliated Hospital
Denver, Colorado
Pathology

William Lee Crisp
Eugene Talmage Memorial Hospital
Augusta, Georgia
Medicine

James McCorkle Davis, Jr.
Massachusetts General Hospital
Boston, Massachusetts
Radiology Residency

Paul McNeely Deaton, Jr.
Medical Center Hospitals of S.C.

Charleston, South Carolina
Medicine

Paul Michael Desrosiers
William Shands Teaching Hospital
Gainesville, Florida
Pediatrics Residency

Mary Catherine Dobbins
Stanford University Hospital
Stanford, California
Medicine

Thomas Harmon Dukes, III
Eugene Talmage Memorial Hospital
Augusta, Georgia
Rotating

Marshall McC. Feaster, III
Walter Reed General Army Hospital
Washington, D.C.
Surgery

John Randolph Forehand
University of Colorado Affiliated Hospital
Denver, Colorado
Pediatrics Residency

James Ewell Graham, Jr.
Duke University Medical Center
Durham, North Carolina
Ob-Gyn

William Melvin Grant
North Carolina Memorial Hospital
Chapel Hill, North Carolina
Ob-Gyn

Margaret Ann Harper
Highland Hospital
Rochester, New York
Family Practice

Stephen Smith Hawkins
Vanderbilt University Affiliated Hospital
Nashville, Tennessee
Medicine

LaFloyd Hueston Hobbs, Jr.
Naval Hospital
Portsmouth, Virginia
Rotating

Sammy Carrol Honeycutt
Spartanburg General Hospital
Spartanburg, South Carolina
Family Practice

James Harden Howell, III
University of Oregon Medical Center
Portland, Oregon
Rotating

Charles Norman Hurwitz
University of Iowa Hospitals
Iowa City, Iowa
Pathology

Lynn David Ikenberry
North Carolina Memorial Hospital
Chapel Hill, North Carolina
Psychiatry

Margaretia Louise Jackson
Children's Hospital
Washington, D.C.
Pediatrics Residency

Joseph McKendrie Jenkins
North Carolina Memorial Hospital
Chapel Hill, North Carolina
Surgery

William Henry Katz
Grady Memorial Hospital
Atlanta, Georgia
Rotating

Levan Nguyen Kuck
Jacksonville Educational Program
Jacksonville, Florida
Medicine

Kenneth Robert Kulp
Hershey Medical Center
Hershey, Pennsylvania
Surgery

John Albert Lang, III
University of Maryland Hospital
Baltimore, Maryland
Medicine

William David Lee, Jr.
Highland Hospital
Rochester, New York
Family Practice

James Andrew Leventis
Charlotte Memorial Hospital
Charlotte, North Carolina
Rotating

Thomas W. Littlejohn, III
Charlotte Memorial Hospital
Charlotte, North Carolina
Family Practice

Clarence Earl Lloyd, Jr.
New Hanover Memorial Hospital
Wilmington, North Carolina
Rotating

John Scott Luther
Charlotte Memorial Hospital
Charlotte, North Carolina
Rotating

Joseph Majstoravich, Jr.
St. Francis General Hospital
Pittsburgh, Pennsylvania
Rotating

Stephanie Kodack Maneß
Parkland Memorial Hospital
Dallas, Texas
Rotating

Charles Frank Margolis
North Carolina Memorial Hospital
Chapel Hill, North Carolina
Family Practice

Jennifer Smith Margolis
North Carolina Memorial Hospital
Chapel Hill, North Carolina
Pediatrics Residency

Philip Lee Martin
Geisinger Medical Center
Danville, Pennsylvania
Surgery

Willis Elwood Martin
Medical College of Virginia Hospital

Richmond, Virginia
Medicine

Shepard Allen McKenzie, III
North Carolina Memorial Hospital
Chapel Hill, North Carolina
Medicine

Wayland Wilson McKenzie
Moses H. Cone Memorial Hospital
Greensboro, North Carolina
Medicine Residency

Daniel Hugh McNeill
Fitzsimmons General Army Hospital
Denver, Colorado
Radiology Residency

William Henry Moretz, Jr.
Vanderbilt University Affiliated Hospital
Nashville, Tennessee
Surgery

Patrick Bowman Mullen
Charlotte Memorial Hospital
Charlotte, North Carolina
Rotating

William Alton Murphy
St. Joseph Infirmary
Louisville, Kentucky
Rotating

Forest Pike Newman, III
Walter Reed General Army Hospital
Washington, D.C.
Medicine

McArthur Newell
Medical College of Virginia Hospital
Richmond, Virginia
Ob-Gyn

Clyde Nolan, Jr.
University of Kentucky Medical Center
Lexington, Kentucky
Medicine

Paul Lanier Ogburn, Jr.
University of Minnesota Hospitals
Minneapolis, Minnesota
Ob-Gyn

Terry Lyn Overby
Strong Memorial Hospital
Rochester, New York
Medicine

Hubert Clifton Patterson, III
Mary Hitchcock Memorial Hospital
Hanover, New Hampshire
Surgery

James Edward Phillips
Spartanburg General Hospital
Spartanburg, South Carolina
Rotating

Harold Calloway Pollard, III
North Carolina Memorial Hospital
Chapel Hill, North Carolina
Ob-Gyn

Jan Hendrik Postma, Jr.
University of Florida Affiliated Hospital
Gainesville, Florida
Surgery Residency

Thomas William Powell
North Carolina Memorial Hospital
Chapel Hill, North Carolina
Surgery

James Butler Puckett
Medical College of Virginia Hospital
Richmond, Virginia
Medicine

Charles Fredric Reid
University of Florida Affiliated Hospital
Gainesville, Florida
Surgery Residency

David Allen Rockwell
University of Virginia Hospital
Charlottesville, Virginia
Surgery

Charles Wilburn Rogers
Geisinger Medical Center
Danville, Pennsylvania
Ob-Gyn

Thomas Oliver Rumley, Jr.
University of Florida Affiliated Hospital
Gainesville, Florida
Surgery Residency

Suzanne Van Houten Sauter
William Shands Teaching Hospitals
Gainesville, Florida
Medicine

Charles Wilson Smith, Jr.
Johns Hopkins Hospital
Baltimore, Maryland
Surgery

Roger Lewis Snow
University Hospitals
Boston, Massachusetts
Medicine

David Earl Tart
North Carolina Memorial Hospital
Chapel Hill, North Carolina
Medicine

David Thomas Tayloe, Jr.
Temple University Hospitals
Philadelphia, Pennsylvania
Pediatrics

Robert Tennant Teeter
Medical College of Virginia Hospital
Richmond, Virginia
Ob-Gyn

Jessica Love Thomason-Moore
San Diego County University Hospital
San Diego, California
Surgery Residency

Darlene Cheryl Thorne
North Carolina Memorial Hospital
Chapel Hill, North Carolina
Pathology

John William Thornton, III
Madigan General Army Hospital
Seattle, Washington
Medicine

Walter Robert Tucker
Duke University Medical Center

Durham, North Carolina
Family Practice

Daniel Castile Vinson
North Carolina Memorial Hospital
Chapel Hill, North Carolina
Family Practice

Max Lee Wallace, Jr.
Mount Sinai Hospital
New York, New York
Medicine

Larry Estel Warren
University of Tennessee Memorial Hospital
Knoxville, Tennessee
Rotating

Hershel Liston Wix, Jr.
University of Chicago Clinics
Chicago, Illinois
Medicine

Charles DeWayne Yoder
North Carolina Memorial Hospital
Chapel Hill, North Carolina
Pediatrics Residency

Douglas Bryan Young
University of Alabama Medical Center
Birmingham, Alabama
Surgery



Charles Harris Weiss
Case Western Reserve University Affil.
Cleveland, Ohio
Medicine

Allan Richard Wenner
Medical Center Hospitals of S.C.
Charleston, South Carolina
Family Practice

Tommie Blake Williamson
Emory University Affiliated Hospitals
Atlanta, Georgia
Psychiatry

Kenneth Heaton Wilson
Boston City Hospital
Boston, Massachusetts
Pathology

Thomas Alexander Wilson
North Carolina Memorial Hospital
Chapel Hill, North Carolina
Psychiatry

William Grady Wilson
University of Virginia Hospital
Charlottesville, Virginia
Pediatrics Residency

In Memoriam

James Richard Brown ('24)
Sidney Eli Buchanan ('10)
Henry Lilly Cook, Jr. ('16)
Lemuel Underwood Crech ('37)
John Wesley Deyton, Sr. ('26)
Thomas Stricker Eddleman ('33)
Clayton Willard Eley ('14)
Glenn Raymer Frye ('19)
James Brownlee Hall ('31)
Clyde Reitzel Hedrick ('23)
James Alton Hill ('55)
Theodore Hyde Kiesselbach ('69)
John Robert Lowery ('02)
Bodie Banks McDade ('16)
Joseph Altira McLean ('24)
Charles White Millender ('15)
Ashley Curtis Norfleet ('23)
Hazel McLeod Riggins ('22)
Robert Alexander Ross ('20)
Ruby Arden Smith ('38)
Sidney Silas Smith, Jr. ('23)
Levi Wade Temple, Jr. ('26)
William Roy Totherow ('49)

Who's where

30's

William Benton Patterson, '34, has just published a book entitled, "Fetal Adrenal Hyperplasia: Its Relationship to Late Toxemia."

Max Novich, '39, has been elected Chief of Staff of the United Hospitals Orthopaedic Center, the hospital for crippled children and adults in Newark, N.J. He is also a Clinical Associate Professor of Orthopaedic Surgery at the College of Medicine and Dentistry of New Jersey, and also on the faculty of Rutgers in Newark and New Brunswick.

40's and 50's

William E. Easterling, Jr., '56, has been appointed Chief of Staff at the North Carolina Memorial Hospital and an Assistant Dean of the UNC School of Medicine. He succeeds William J. Cromartie, who will continue as Associate Dean for Clinical Sciences in the School of Medicine.

"Ken" Willis, '50, has retired from military service and is living in Gastonia.

Louis C. Spillman, '54, writes that "for the record" he is employed by an Anaheim, California, engineering-technology-construction firm. He is now Chief Medical Officer based on Johnston Island, a small atoll some 800 miles southwest of Hawaii.

Rebecca Buckley, '58, an Associate Professor of Pediatrics and Immunology at Duke University Medical Center, is employing newer techniques in the study of lymphocyte function in patients with chronic respiratory infection.

Capt. James W. Fresh, '57, is an Executive Officer with the Naval Medical Research Unit No. 3. He is in Cairo, Egypt, with his family. He writes, "Our motor fuel has been rationed since October, 1973. The family is used to bicycles."

R. A. Worsham, '44, formerly an Orthopaedist, has left Florida for the life of a North Carolina country realtor. He has been in the process of finding a second career for the last five years. After closing his offices in Florida, he worked alternate weeks at a local hospital. Every other week found him back in North Carolina at Lake Toxaway, where he owned land in those mountains. Now he is a realtor there.

60's

C. R. Fleming, '69, has completed his training in internal medicine. He is now in his second year of gastroenterology training at the Mayo Clinic. He plans to spend next year at Davis, California, before returning to Rochester.

Carl T. Whiteside, '69, is now serving two years in the Navy. After completing his post-graduate work at Tulane, he was assigned to the Isle of Palms, S.C. His address there is 103 Shady Lane. The zip code is 29451.

Bruce F. Caldwell, '63, in Clinton, N.C., and Step Shaffer, '63, who is a plastic surgeon in Virginia, became Fellows of the American College of Surgeons in October 1973.

William B. Deal, '63, is currently an Associate Professor of Medicine in the Division of Infectious Diseases and an Associate Dean at the College of Medicine at the University of Florida in Gainesville.

Ronald L. Mauldin, '64, is in the private practice of neurosurgery in Gainesville. The Mauldins live at 1511 N.W. 48th Terrace, zip code 32601.

Edgar C. Garabrant, '66, has joined the Raleigh Ear, Nose and Throat Clinic.

Rud Polhill, Jr., '68, spent from 1971 to 1973 in the Navy. He followed that with an internship and residency in pediatrics at the University of Alabama Medical Center, during which



time he was Chief Resident. Now he is a Pediatric Fellow in Infectious Diseases and Immunology at Alabama. He writes, "My research is focused on the role of the spleen in the production of the humoral factors influencing phagocytosis in the absence of the specific antibody. I plan to do basic clinical research and teaching in pediatric infectious disease." He said that he was delivered by Daddy Ross, and Rud vividly recalls that, among the advice Daddy handed out was, "You don't have to be brilliant to be a good physician. You only have to be morally honest. When the telephone rings at 2 a.m., you don't need brains, you need professional and moral honesty. That's all, and that's enough." Rud and his family write that they miss Chapel Hill.

Llewellyn Phillips II, '65, is now in practice in Renton, Washington, with the Valley Dermatology Clinic.

Don Nelms, '64, and Larry Mumford, '67, have settled in Fort Worth, Texas. Don is director of the Department of Pediatrics at John Peter Smith Hospital, and Larry is Assistant Director of the department. They are full-time, hospital-based physicians for a community hospital. The Nelms' household consists of Beverly and three children: James, 11, Elizabeth, 5, and Thomas, 4. Alice and Larry Mumford have two children, Susan, who is 6, and Michael, 4.

70's

George H. Underwood, Jr., '73, is in Tacoma, Washington, for a straight medical internship and residency. He says that he is very happy there and "couldn't ask for better patient population." He is fishing and skiing in his spare time. Address: Box 794, Madigan Army Center, Tacoma, Wash. 98431.

Richard M. Freeman, '70, has moved from Birmingham to 2648 Shenandoah Drive South, Orange Park, Florida 32073. He is currently staff pediatrician at the U.S. Naval Hospital in Jacksonville.

Dewey and Lance Walker, '70, are at the University of Colorado. Dewey writes that, "Lance is doing a residency in general and cardiovascular thoracic surgery. I am taking a year off to stay home with one-year-old Caroline to learn some practical pediatrics. Next year, I will complete pediatric training with a fellowship in child development."

Roy Schindelheim, '71, has been named deputy in charge of medical services for the Office of Veterans' Services, Washington State Department of Health and Social Services. He is responsible for the evaluation and strengthening of all of the medical and related programs at three veterans' homes in the area.

Dr. Joseph Patrick Archie, M.D., class of '68, was presented "the Young Investigator Award" at the recent meeting of American College of Cardiology in New York for the excellent paper presented on his research contribution on myocardial blood flow. Dr. Archie is chief resident in Surgery (Cardiovascular) at the University of Alabama Medical Center in Birmingham. During this period of graduate training he spent sixteen months as a research associate at the Cardiovascular Research Institute, University of California School of Medicine at San Francisco.

After military service he will return to the University of Alabama Medical Center as a member of the faculty of the Department of Surgery in 1976.



Four Alumni Win DSA's

The growing need for alumni cooperation and participation in community medical education was emphasized at the Annual Meeting of the Medical Alumni Association on March 13. Approximately 300 attended, the largest meeting of the alumni to date.

In addresses to the luncheon meeting and to the Visiting Committee, Dean Christopher C. Fordham III stressed the importance of the alumni's teaching role in the school's expanded community outreach programs. These programs, which have been very well received by the students, represent the school's effort to make medical education as responsive and productive as possible.

The Dean punctuated the school's attempts to increase the flexibility of the curriculum while meeting very

real patient needs in his special afternoon address, "Medical Education: The Issues." In this presentation, he outlined the Board of Governors' "Statewide Plan for Medical Education," explaining how the proposed plan spoke to the demonstrated need for better patient care.

The alumni were also told that the school has maintained its high standards through recent curriculum modifications. Students who took Part Two of the Nation Boards this year placed third in the country. Of 95 graduating seniors, 70 received their first choice in the matching program. Twenty-four students will be interns in medicine, 20 in surgery, 7 in pediatrics, 8 in obstetrics, 2 in radiology, 9 in family medicine, 5 in pathology, 4 in psychiatry, and 16 rotating.

Dr. Lewis S. Thorp, President of the Alumni Association, described a tentative plan for combining the Offices of Continuing Education, Alumni Affairs, and Medical Studies to provide a comprehensive center where the alumni could have a lounge and learning center with staff offices in the same area. He has been assured that the alumni would receive this space, "hopefully within the next year."

Alumni gifts to the Loyalty Fund - the largest amount in the history of the school - have pushed the space for alumni and the Burn Center several notches closer to reality. Unrestricted monies given during the past year total \$19,000.

Dr. William E. Easterling, new Chief of Staff of the North Carolina Memorial Hospital, set as one of his goals the improvement of relationships between the hospital and referring physicians. In remarks made to the Visiting Committee, he requested that any problems or

suggestions be directed to him. Dr. Easterling, the first chief of staff to be chosen from senior faculty, succeeds Dr. William J. Cromartie, who continues as Associate Dean for Clinical Sciences.

At the annual alumni banquet Dr. Thorp introduced the new President of the Alumni Association, Dr. Julian S. Albergotti, '55 of Charlotte. Dr. G. Reginald Tucker, '55, of Henderson is President-elect. John L. McCain, '50, of Wilson was chosen Vice President. The new Treasurer is Palmer F. Shelburne, '55, of Greensboro.

Newly elected Councillors, whose terms expire in 1977, are Archie D. Walker, Jr., '54, Edenton (District II); Charles R. Vernon, '50, Wilmington (District VI); Robert F. Noel, '61, Henderson (District VII); John L. Monroe, '62, Sanford (District XI); Willis J. Grant, '54, Winston-Salem (District XIV); Dean C. Jones, '56, Jefferson (District XVII); and D. Carl Biggers, '58, Asheville (District XIX).

W. Paul Biggers, '63, of Chapel Hill, and Zebulon Weaver, '61, of Asheville, were chosen Councillors-at-Large. Morris A. Jones of Durham will fill an unexpired term ending in 1975. He is a member of the class of 1959.

After dinner Dean Fordham presented the Distinguished Service Award to five persons, four of whom are alumni. Mrs. Martha Love Ayers, Dr. Sarah Taylor Morrow, Dr. George Denman Hammond, Dr. Corbett L. Quinn, and Dr. Nathan A. Womack received the School of Medicine's highest honor.

Mrs. Ayers was cited for her contributions to educational institutions in North Carolina and for her continued interest in medical education and medical care. (A picture of Mrs. Ayers was not available.)

Dr. Morrow's work as Director

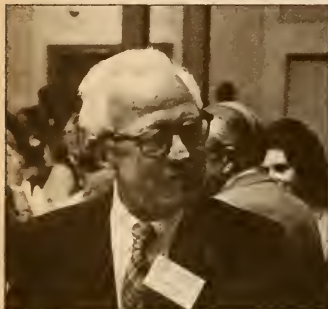
of the Guilford County Health Department in developing a nationally recognized Comprehensive Children and Youth Project earned her the award. Both Dr. Morrow, '43, and Mrs. Ayers are from Greensboro.



Dr. Hammond, '46, Associate Dean of the University of Southern California School of Medicine, was honored for his research contributions in establishing National Cooperative Study Programs dealing with malignant diseases in childhood. In addition, Dr. Hammond serves as advisor and consultant to the National Institutes of Health in the areas of childhood malignancies and hematological problems.

Dr. Quinn, '51, was honored for professional and personal contributions to his community. Dean Fordham characterized his "model

family practice" as evidence that "the highest quality medical care can be delivered in a rural setting." Dr. Quinn, who has been active in civic organizations, is a past mayor of Magnolia.



Dr. Nathan A. Womack, '22, first chairman of the Department of Surgery, received a standing ovation when his name was announced. One of a very few faculty members to receive the award, Dr. Womack was credited with helping shape the School of Medicine's goals when it became a degree-granting institution. Upon his retirement as chairman, colleagues and students formed the Nathan A. Womack Surgical Society, which awards an annual scholarship to the senior surgical resident who best epitomizes "the qualities of Nathan A. Womack - general excellence in teaching, investigation, and patient care."



A Very Good Year...

It was a very good year, 1954. At least it was for those who received the first Doctor of Medicine degrees granted by the UNC School of Medicine. Hugh Hemmings, Class Agent, organized a gathering of the faculty members and students who banded together to start the degree-granting program.

Invited guests included 42 members of the faculty who are still teaching, "despite having taught that class." Special guests were Dean Emeritus W. Reece Berryhill and "Peaches" Dunlap. Dr. Berryhill accepted two University chairs the class gave him and Dr. Ed Hedgpeth, their advisor. Dr. Hedgpeth could not attend, although the class members had hoped he would

come and reveal the contents of his little black notebook. In it is recorded data and forecasts of the futures of his advisees. After he learned the class had given him a chair, he reported that they might have taken it back HAD they known what was in his notebook. Peaches, Dr. Berryhill's assistant and enforcer for many years, was made an honorary member of the class. She was given a silver Revere bowl, the "only silver one I have." She says it sits on her sideboard and she looks at it daily.

Seventeen members of the class and their spouses, joined by faculty and friends, kept the guests at the Inn awake. Reports in the popular press have stated that a team of researchers have found that 20th reunions are often "depressing" events. Members of this class didn't seem to think so, and Peaches swears they don't look any older to her.

What Is A Good Doctor?

by Katherine Lewis

What is a good doctor? One with superb technical skill? Human empathy? Ability to make his patient feel important? These and other questions were the focal point of the recent Anglo-American Conference on Continuing Education at the UNC School of Medicine.

Throughout the conference, participants examined the processes that

go into making and maintaining a good physician - admissions procedures in medical schools, methods of teaching medical students, techniques offered practicing physicians for renewing their knowledge and standards for evaluating physician competency.

Dr. John F. Stokes of London's Univeristy College Hospital voiced the goal uppermost in the minds of the participants - achieving balance in the face of increasing complexity. Speaking on the question of periodic relicensure of practicing physicians, Dr. Stokes warned that, "our evaluation procedures have not yet reached a stage of development at which a recertification test could be completely meaningful."

If criteria are not developed, Stokes cautioned the participants, the quality control supposedly exercised

by recertification will mean that doctors will work half their lives for "a test which might have little relevance to their patient's needs." The complacency induced by objective tests, he said, may lead to the production of doctors who could practice only a "baroque and castrated medicine" instead of achieving the balanced link between professional skill and mastery of knowledge that characterizes the true professional.

Dr. Christopher C. Fordham, dean of the UNC School of Medicine, advocated viewing lifelong medical education as a continuum which begins with the selection of students for medical school. He acknowledged that criteria for student selection are still crude. Nevertheless, he said, admissions committees should try to choose those candidates who are most



likely to display "a continuing devotion to the scholarship of medicine." That, the group concluded, plus the increased use of a variety of teaching methods - - among them self-instructional programs - - are factors most likely to induce students to take advantage of continuing education as practicing physicians.

The United States and the United Kingdom both have taken innovative steps toward realizing educational balance through the regionalization of medical education. The Area Health Education Centers (AHEC) in this country parallel the UK's post-graduate centers. The AHEC system is a partnership between universities and community hospitals in which the university's goal of education and the hospital's goal of service to the community are combined, according to Glenn Wilson, associate dean for Community Health Services at the UNC School of Medicine. Dr. John Lister, regional postgraduate dean of London's North West Metropolitan Region, described the post-graduate



centers, which provide multidisciplinary educational programs for physicians and other health professions in a given region.

Situated close to a local hospital, each postgraduate center is directed by a clinic tutor, who, according to Dr. Lister, coordinates and plans the academic programs according to the needs of the local physicians. Termed, "one of the most significant developments in the United Kingdom in recent years," the centers have proved a valuable link between universities and formerly isolated family practitioners he said. The AHEC program strikes a balance between academically and community-oriented training, Wilson stated, by informing local physicians of recent medical advances, assisting in the development

of educational programs for other health professionals and conducting on-the-spot training for students and residents from medical schools.

Dr. Stokes voiced the challenge facing physicians today, "The most urgent charge for those entrusted with the responsible task of training and evaluation (which are simply two sides of the same coin) is to decide what it is they are hoping to see emerge at the end of the road."

UNC Medical Alumni Bulletin
226 MacNider
Chapel Hill, N.C. 27514

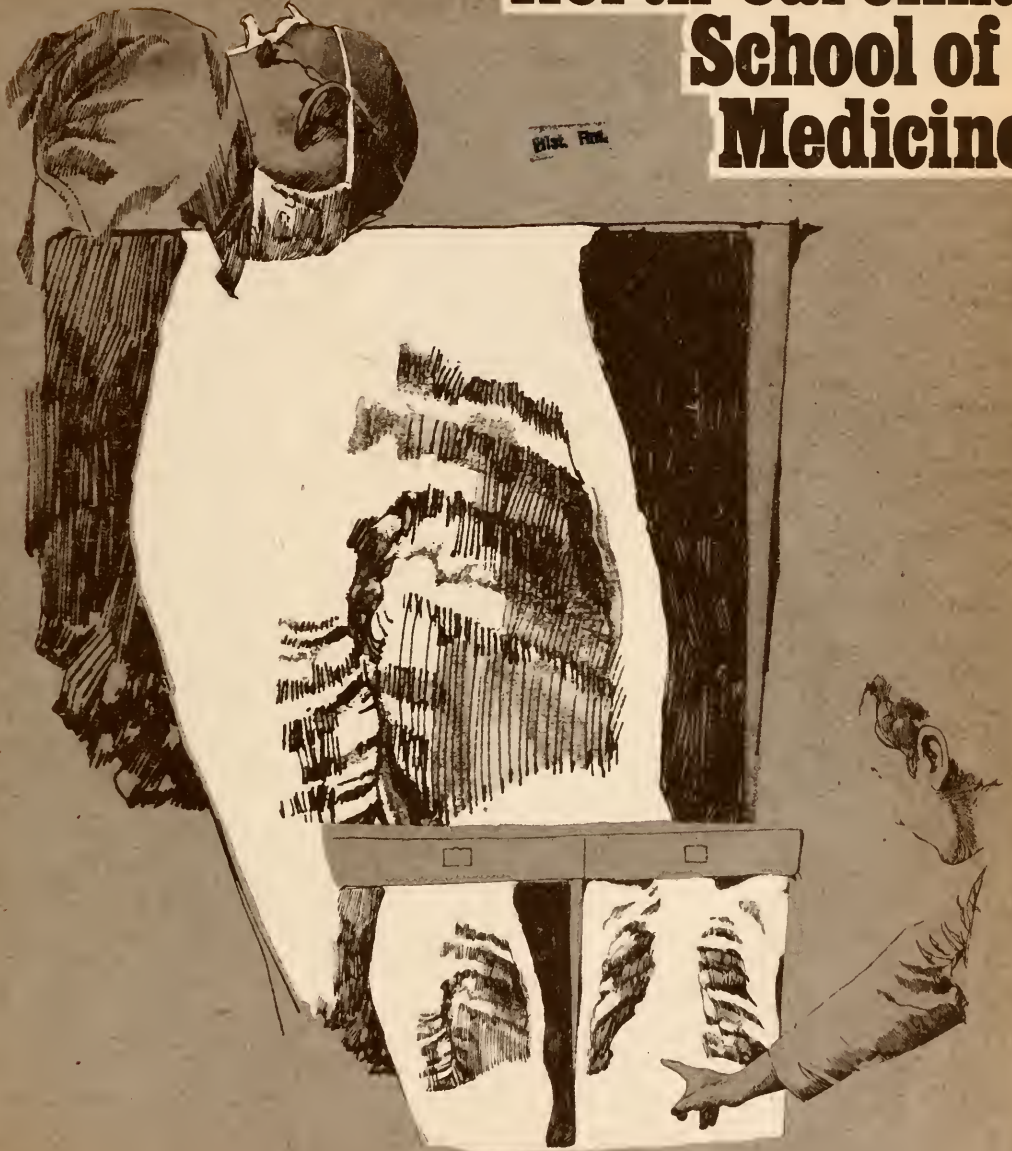
Cut here and let us hear from you.

UNC Medical Alumni Bulletin
226 MacNider
Chapel Hill, N.C. 27514

Non-Profit Organization
U. S. POSTAGE
PAID
CHAPEL HILL, N.C.
PERMIT NO. 24

University of North Carolina School of Medicine

Dist. Free





University of North Carolina School of Medicine



Who is a good doctor?
What is a good doctor?
How does one know how
to be good to himself so that he
is good for his patients?

This Summer Bulletin
offers you some help.

First, we have an article
by an anonymous internist who
tells how he sets standards for
himself and for patient care.
His dry wit sparkles through in
a very good piece. His insistence
on anonymity, understand, is
really not a feeble attempt at
modesty. He submitted the man-
uscript we asked for in a plain
brown envelope and marked an
enclosed note, "Anon." There-
fore, you know you have the
whole truth and nothing but . . .
except that we hear in the halls
of the hospital he makes nurses
cry.

Dr. Nathan Womack has
written a thoughtful piece about
the turmoil in medical education
today, tracing it from Roger of
Sicily to the Seventies. He has
his own strong ideas about what
medical schools owe their grad-
uates after they get the degree.
You'll be pleased to see that
he thinks we owe you, not vice
versa.

Finally, we have a respect-
ful romp through UNC's School
of Medicine development in a
reprinting of the graduation
address of Dr. James A. Bryan,
II, with a special poem by
Assistant Dean of Student
Affairs, Marion Phillips.

Again, there is a form for
collection news notes, or those
you've collected from friends.
Let us hear from you.

Bulletin Advisory Board

William Blythe, M.D.

John Herion, M.D.

John Sessions, M.D.

Raymond Wheeler, M.D.

Nathan Womack, M.D.

Oscar Sapp, III, M.D.

Chairman, Ex-Officio Member

Katherine Lewis

Editorial Associate

Cheree Briggs, Editor

Credits

Photographs by Maury Faggart
and Ann Hawthorne

Design. Gibbs Associates, Inc.

Table of Contents

"Shiny Pants and Big Ears Make Good Doctors"	4
I, and We, Owe YOU	9
126 MacNider	15
Of Chalk, Classrooms and Clinics	16
Who's Where	22
Two "M's," a "W," and Modern Medicine	25

The Bulletin, of which this publi-
cation is Volume 20, No. 3, is
published quarterly by the UNC
Medical Alumni Association,
Chapel Hill, N.C., 27514. Postage
is paid by the non-profit association
through U.S. Postal Permit No. 24

"Shiny Pants and Big Ears Make Good Doctors"

Editor's Note: The Editorial Board asked this clinical faculty member to write his personal view of what it means to be a good doctor. He consented, if he could do so anonymously. He suffers from a chronic, acute case of modesty.



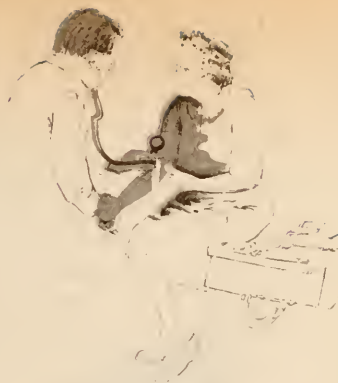
"What is a good doctor?" The answer seems obvious enough at first glance, and when, as a practicing internist, I set out to define "goodness" as it applies to my profession, I anticipated that the task would be quite simple. But as I proceeded with my analysis, I began to realize that the problem was much more complex than I had first thought. Further, I found myself wrestling with a parallel question: does "goodness" mean the same thing to the doctor's patients as it does to the doctor's peers, or perhaps more fundamentally, to the doctor himself? It is only by looking at the way goodness is defined from each of these points of view that one can piece together the whole picture of a "good doctor."

Let us begin with the patient. How does he decide if a doctor is good? How valid is his analysis? Naturally, most patients are pleased when, as a result of their encounter with a particular doctor for a particular problem, they get well. Perhaps this is the reason so many women are so fond of their obstetricians, who always cure them of their pregnancies, and almost always with a "happy ending." Those of us in other specialties, where the natural history of the problem at hand is not quite so predictable as with pregnancy, know that some of our most grateful patients are the ones who have come to us with acute or self-limited illnesses from which they have made a rapid and

complete recovery. How gratifying it is, for example, to treat someone with pneumococcal pneumonia and observe the dramatic resolution of symptoms as penicillin works its magic. Naturally, the beneficiary of such treatment will define as "good" the doctor who administers it. And yet, plenty of physicians can recall the days before penicillin was available, when the physician's only tools against the pneumococcus were a strong patient and a little bit of luck. I remember the story of my own grandfather, a rural GP, telling his wife and children that his own fifteen-year-old daughter was probably going to die because she had "double lobar pneumonia." He prescribed a dark

room, a croup kettle, aspirin, and expectorants; then, with the rest of the family, sat powerless by the bed waiting for the crisis which, fortunately, was followed by recovery rather than death. Now, thirty-five years later, family legend has it that grandfather "pulled Aunt Peggie through" pneumonia, just as he has pulled others through diphtheria, rheumatic fever, polio, and the other scourges of those times. Few, if any, of my grandfather's patients would quarrel with the notion that he was a "good doctor", despite the fact that the outcome of their illnesses was little affected by any of the scientific treatment he rendered. I stress "scientific" because I want to emphasize that my grandfather knew what many of my generation have forgotten - that patients and their families can be "treated" by a good physician even when the disease within the patient cannot. Perhaps Voltaire put it best: "The function of the physician is to amuse the patient while nature makes him well." I would add to this marvelously accurate observation that the physician must also at times comfort the patient while, as with many chronic ailments, nature takes its course. If he does so, then whatever the outcome of the illness - recovery, chronic illness and disability, or death - the physician will rightly be acknowledged as having done a "good" job.

Here one must sound a cautionary note about the

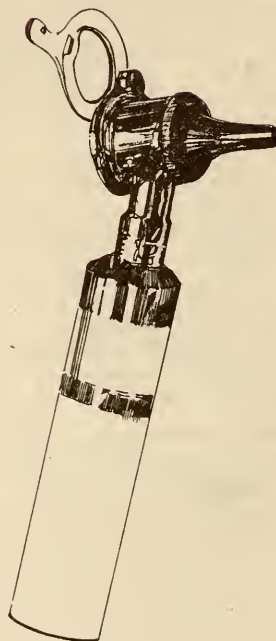


validity of accepting uncritically a patient's assessment that a physician is good. As I hope is evident from the examples I have just given, the physician can be judged "good" by the patient for simply having stood by him through an illness, whatever the outcome, and while such devotion by the physician is requisite to winning the patient's favor, it certainly should not be sufficient to satisfy completely the definition of a good doctor. For example, I overheard a friendly, sympathetic doctor responding to a patient's question about her blood pressure, "Yes, it's just fine, 160 over 110. Nothing to worry about." Assuming the patient's blood pressure remains at this level, she is much more likely to have a stroke than is her normotensive counterpart, no matter how kindly her doctor treats her. In other words, she

needs antihypertensives more than she needs TLC. All of which is by way of saying that the patient can recognize the "art" with which a physician practices, but he cannot judge the scientific validity of the treatment rendered; this he must leave to the doctor's peers.

How do doctors go about deciding if another doctor is a good one? Nowadays, physicians are having to ask themselves this question more and more, as they are required by various agencies to perform peer review and establish Professional Standards Review Organizations. Even before these review procedures were necessary, however physicians were performing the same function on a less formal basis through the process of choosing consultants for their patients and physicians for themselves and their families. Surely in the process of making these selections they were asking themselves the question, "Is this man or woman a good doctor?" But can we be sure? How important is "goodness" to the process of consultant selection, and how capable is one doctor of deciding that another is good? A cynical colleague has suggested that one doctor refers patients to another on the basis of "availability, affability, and ability, in that order." While I suspect there is more than a little truth in this formulation, I hope and believe that most doctors size each other up more "scientifically" than that. But how?

As I have intimated, the peer review process is one which is being used more and more widely as a means of defining acceptable standards of practice. I would like to think that through it, physicians will be able to judge one another's scientific competence by applying scientific criteria, and by so doing, be able to decide if the doctor under review is "good" in the "scientific" sense of the word. If we again use the example of pneumococcal pneumonia, then we might define the good doctor as one who records a complete history and physical examination, requests a complete blood count, a chest x-ray, a bacteriological study of blood and sputum, begins treatment with penicillin, and makes frequent progress notes about the patient's response. The physician who meets these standards is most likely a good scientist, but he may or may not be a good doctor. If, for example, after diagnosing and prescribing for the pneumonia, he refuses to return a call from the patient's anxious mother, or if he is "too busy" to reassure the patient and his family that



the pneumonia is responding to treatment, then he certainly falls short of our definition of a good doctor, even though he has sailed right through the scientific standards imposed by the peer review process.

This is not to say that one physician is incapable of recognizing the "art" as well as the science with which another practices. To the contrary, some of the most telling statements I have heard about the "art of medicine" have come from other physicians. "The good doctor has shiny pants and big ears" was a definition often repeated by one of my teachers in medical school, indicating his awareness of how important it is for the doctor to sit and listen to his patient. "Yes, he's a good orthopedic psychiatrist", one of my partners rather drolly told me one day when I asked him if a certain orthopedist would be sympathetic towards a neurotic patient with chronic functional back pain. I think we can see from these examples how one doctor recognizes another as good, not necessarily just be-

There are no simple answers to these questions, but a few points concerning them do bear emphasis.

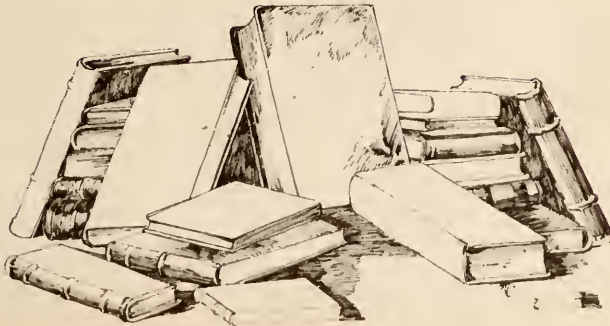
In the first place, every doctor should know that it is the height of self-deception to rely solely on the judgement of his patients. As we have seen, patients are not likely to be objective about their own doctors, but rather base their opinions on observations made under the stress of illness, when objectivity is most difficult to achieve. A physician friend of mine never tires of reminding me that all doctors are beloved by their patients for the very simple reason that those patients who do not like a doctor will go to another one, leaving behind only those who do like him. We physicians should remind ourselves of this fact periodically, especially when we begin to feel a little god-like as a result of an unusually heavy dose of praise from a grateful patient.

When I was in medical school, the drift away from primary care into highly

specialized fields was at its peak, and in an effort to attract some of us students back into general practice, a local GP was invited to tell our class about all the advantages and rewards of his field. He was a man of about sixty, and I remember vividly that he spoke not of scientific challenge or of the satisfaction of providing the community with a needed service. Instead, he told us how good it made him feel to be recognized and waved at by little children when they saw him driving down the street. "How nice," I thought, "but how dangerous to leave the assessment of one's worth

cause he is a good scientist, but because he is also willing to listen, to "care" for the patient.

Having explored the ways in which a doctor's patients and colleagues might respond to the question, "Is he a good doctor?", I'd like to turn now to what I feel to be a more relevant and fundamental question: namely, "Am I a good doctor?" That is, how can I, as a physician, decide if I am doing a good job? Can I base the answer on the approbation of my patients and colleagues, or must I seek other evidence? What criteria of self-assessment should I apply?



solely to the approval of little children."

It is equally dangerous, I believe, to rely on our peers for a decision about whether we are good doctors. Through peer review and the other avenues by which physicians assess each other, we can infer that the quality of our practice is not egregious; that is, that we meet certain minimum standards, but in no way does such peer approval mean we are good - - any more than the absence of pain means we are healthy.

In the final analysis, only the physician himself can answer the question, "Am I a good doctor?" I contend that there are very few concrete criteria which serve to guide that assessment, for "goodness" in a physician, as in anything or anybody else, is not a quantity, but a quality. Nevertheless, there are some markers on the trail of self-assessment, and I believe that if a doctor can answer the following questions affirmatively, chances are he is doing a good job.

First, do you like what you do? Acknowledging the frustrations, the unreasonable demands, the enervating fatigue which afflict all doctors from time to time, do you still enjoy practicing medicine? If you do, then you obviously also like people, specifically the sick people we call patients, and because you do, you have fulfilled the most important and best known tenet of medical practice: "The secret of patient care is in caring for the

patient." Implicit in this epigram is the physician's willingness to treat all his patients as equals, surrendering to each according to his needs that most precious of commodities, time. A wise maiden aunt told me the day I started my practice, "Remember, sweetheart, every patient you see will have a mother, or a spouse, or children, or someone to whom he is very special, so treat them all just as you would treat a member of your own family. Be patient and kind, even though every one of them might be as eccentric as I am." To say it another way, "Do unto others as though they were yours." Succeed in keeping this modified golden rule, and you have come a long way toward becoming a good doctor.

Second, do you know what you do? To my mind, the good doctor is one who knows his limitations, who strives conscientiously to stay abreast of his field and who readily requests consultation for cases with which he is uncomfortable. He is one who learns from his experience as well as from his journals. rather than like one old man whom I heard described by one of his fellow physicians as having had not thirty years of experience, "but one year of experience thirty times." The good doctor knows more than science; he knows about the stresses of modern life, about the impact of rapid or radical change on the patient, his family, and their relationship with each other and with their environment. In other words, the good physician is an ecolog-

gist and a social scientist, as well as a physical scientist.

Third, are you satisfied with what you do? When the day is over, can you look back on it and say honestly, "I have done the best I know how. To have done it well was worth the effort and the sacrifice."?

Answer these questions affirmatively out of your own knowledge and conscience, disregarding as biased the praise of patients and colleagues, then as nearly as we can define him, you are a good doctor. Whether you remain one is entirely up to you.

Remember

Medical Parents Day
October 26.

The Medical Alumni
Council Meeting November 2. Meet for lunch and the UNC/UVA football game.

Atlanta... the place to be ...November 18

That's the date of the UNC Medical Alumni Social Hour during the meeting of the Southern Medical Society. The time's 6:30 - - location to be announced. Mark it on your calendar now, and DON'T MISS IT!!!

“I, and We, Owe You.”

Nathan A. Womack, M.D.

Practically everyone has in his mind an image of what the ideal physician should be, although it often differs. Perhaps basically, the image is that of a physician who knows what he is doing and who cares for his patient. Now let us bind these two attributes with what I shall call clinical style. Style in the sense that I want to use the word as the dress in which these two qualities are protected and expressed. Each physician employs style in his own peculiar manner, often varying it to conform to the personality and needs of a particular patient. In such a way, we design in our own minds the idealized prototype of the good physician.

The problem that confronts the medical educator is that of bringing this prototype into being. It is not at all simple; it is complex. There are many questions at issue, and these are attended by medical requirements that differ with our social and physical environments. At the present time, these environments are in a state of turbulence, and nowhere does this turbulence reflect itself more acutely than in the delivery of medical care. This, in turn,

will concern our concept of the nature of the good physician.

As we seek order in our considerations, we encounter an extraordinary paradox. We recognize that improvement in medical knowledge and patient care have been striking during the past few years. So true is this that it is fair to say that during the past few decades nowhere in the story of Western culture can anything quite match the achievements of American medicine during this period of time, achievements due to advancement in scientific knowledge. Great inroads have been made in the prevention of sickness and pain. Many diseases, previously widespread and feared because of high morbidity and mortality, have almost completely disappeared. Others are coming under control. Hospital and ambulatory care have shown almost revolutionary improvement. Preventive medicine and public health procedures are being expanded constantly. Prepayment medical and hospital insurance has been fostered, and a vast number of people are now covered for medical and hospital expenses with what amounts to

a reasonable cost. Public polls show medicine to be the most highly respected of all professions and physicians the most respected of all persons.

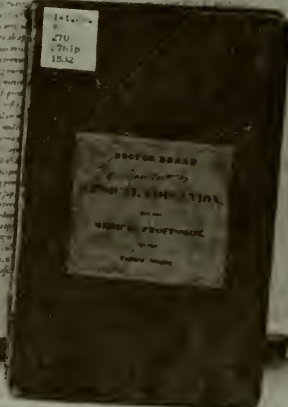
There is running parallel to these accomplishments, however, a growing public discontent with medicine. There is almost a continuous complaint of the lack of availability of adequate medical care, especially documented in many rural areas and in ghetto districts in cities. There is, therefore, a demand for better distribution of physicians. While, as society becomes more prosperous, one might try to discriminate between medical desires of a more or less trivial nature and true medical needs, the widespread assumption of a numerical shortage of physicians remains. The cost of medical and hospital care is at time exorbitant. It needs adjustment badly. This bothers our legislators and the U.S. Congress, who are becoming increasingly concerned with the economics of medical care. A finger is often pointed at physicians because of apparent financial greed. Malpractice suits are becoming more frequent with larger

CEINTA

此乃



CHARACTERVM QVINTI MUSEI

[illegible]

judgments against the physicians. One frequently hears the complaint of an impersonal approach of the physician toward his patient. All of this results in an almost nostalgic desire for the return of the family doctor of a past generation. Those of us who teach find ourselves almost daily confronted with such a notion as the solution of our medical evils.

Such then is our paradox and we must resolve it.

Even slight consideration shows that what is presented here is not a new problem at all. The public has always wanted a knowledgeable physician and a personal and kindly one. The public has also wanted to pay for these services and therefore wished them at a level that could be afforded. For most of the public I doubt if these wishes have ever really been attained. Nevertheless, many are the essays and commencement addresses that have been directed toward this goal. The years may modify the essays and talks, but basically they remain the same.

The medical educator, then, has not been unaware of the problem. Historically, one notes that the drive for more knowledge has received more of his attention than the acquisition of the attribute of compassion. The reason for this may be that not only is knowledge more difficult to obtain, but perhaps also because of a realization that well-informed action usually accomplishes more than uninformed action, however kindly intended. It has often been sadly demonstrated that uninformed action can at times be disastrous.

This need for medical knowledge has been considered so important that over the years legal restraints on ignorance on the part of the physician have been enacted. We even encounter this in the legal codes of the Babylonian Empire. Examinations for competence were first introduced to exclude the ignorant physician from practice. This perhaps first appeared in the 12th century at Salerno during the time of Roger of Sicily. Representatives of the Emperor met with the faculty in Salerno to determine the proficiency of the candidate to practice medicine.

Again, a century later, Frederick II reaffirmed this same facility, but with greater detail. A candidate for the practice of medicine had to pass an examination given by the faculty at Salerno, but officials of the State were present, and the license to practice was issued by the Emperor or his representatives. There were, however, other qualifications needed than passing the oral examination, which incidentally often lasted as long as two weeks. A preliminary preparation of three years of logic was needed, equivalent to our liberal arts education of today. This was followed by five years of medicine. At this time, the candidate was examined by at least three of the "Salernitan Masters". He was not even then allowed to become an independent practitioner until he had served one or more years of preceptorship under a designated physician. All of this sounds amazingly modern 750 years later. In the 13th century, too, we see a lack of confidence in the examination process, and

thus reinforcements through a prescribed curriculum and a stated period of study.

Unconsciously, or perhaps consciously, our medical schools and licensing and certifying boards today buttress their examinations in the same way. This effort at establishing a linearity between the amount of knowledge a candidate may possess and the time and method spent acquiring it has thus become widespread. To make certain that the school in which the student's education takes place provides the proper environment for learning, special agencies have been formed to inspect at regular intervals the curricula and the facilities in which medicine is learned, as well as stipulate the length and time spent studying particular subjects.

In the United States, these educational rigidities were applied to medical schools in the immediate post-Flexnerian period, although in some schools they existed earlier. These were built-in rigidities which were uncomfortable. Educational experimentation was hampered. Nevertheless, as long as medical schools were primarily concerned in graduating a student with homogenous interests, this type of academic structure functioned reasonably well. Out of it emerged fairly well-educated general practitioners of some years ago. On the whole, they performed well. But as different phases of medicine became more sophisticated — surgery, pediatrics, obstetrics and psychiatry, for example — this type of educational pattern became inadequate. Specialization developed and

medicine became pluralistic in nature. Any single prototype of a physician could no longer be the ultimate aim of medical education.

To regulate these diverse interests, postgraduate programs were developed by hospitals, and they were superimposed upon the educational process beyond the medical school level. Specialty certifying boards evolved to monitor the effectiveness of this education. This advanced specialty training is now so universal in this country that the vast majority of medical school graduates enter into some form of post-graduate or residency education. This is dramatically illustrated in a recent study by Levit and her colleagues.

"Of the 1960 graduates whose career choices were then recognized by established specialty boards, 99 percent entered residency, 86 percent completed residency and entered the certification process, and 73 percent achieved specialty certification."

Since at that time the specialty of family practice had not been established, they ventured the conclusion "that during the 1970's, virtually all United States graduates will undertake specialty training and specialty certification".

A short while before this study was completed, a report to the National Board of Medical Examiners by its committee on Goals and Priorities called attention to the fact that the medical student upon graduation is not completely prepared for the independent practice of medicine. His education must continue

and this usually in some type of residency program. The committee recommended that this continuation of education be a responsibility of the medical school and not of isolated hospitals, and that medical education be considered a continuum with testing of competence at particular intervals.

The picture of a present day pluralistic physician now begins to emerge. We do not have a single physician image. We now have many physician types. In establishing these different types, it is essential for us to have scientific and clinical competence that we can rely upon. This will require accurate testing. While good methods exist, they must be improved upon constantly and better development of such testing must come about. This will require the participation, not

only of the teacher, but also of the student and the practitioner. Such testing should never be thought of as punitive, but as educational. Anyone who participates in such tests should do so seriously and critically and not simply to play a statistical role, for he has much to contribute. The ultimate goal, one still in the future, is to develop tests of such validity and reliability that time spent in acquiring knowledge, and the place in which such knowledge is required, will no longer be dominant factors. They will be, at best, guides only. And finally, we must learn to test not only what a physician knows, but what he does with this knowledge, his actual clinical performance, his behavior under all circumstances. As can be seen, the development of knowledge, and the knowing when this has been accomplished, is not easy.

But what of compassion? How can this important facet in the makeup of a physician be satisfied? Human sympathy is basic to us all, an important difference in the biologic systems of man and most lower forms of life. We thus do not need to instill it, to teach it, for it is present and deep in practically every student who enters medical school. The desire to be of help to one's fellow man is generally the basic motive for studying medicine — sometimes even expressed by an applicant to an admissions committee, but usually not for fear of being thought sophomoric. The pedagogic problem becomes one of

not letting this quality atrophy, in providing an atmosphere in which it rationally can develop. Such a development requires intimate relationships between the student, the patient, the patient's family and the teacher. It is best done by preceptorship, but preceptorship at its best. Not only, therefore, must means for such contacts be provided, but the teacher must participate. If the physician is not deeply concerned with the devastating effects of pain and disease on his patient and the patient's family, he stands a poor chance of presenting this problem to his student.

Fulfilling Osler's prediction, the full-time teacher has not fared well in this respect. The pre-clinical scientist, who has had no direct clinical experience, is handicapped. Many have had no direct contact with an ill person outside of their immediate family. The clinical scientist, striving for the accolade of his colleagues through scientific productivity and the development of clinical finesse, too often finds a lack of time for such personal approaches. Too frequently, this responsibility is passed down the line to the resident staff. The development of group practice with the usual limitations of hours "on call", the advent of the physician's assistant, the nurse physician and the use of numerous technical assistants have all tended to limit the intimacy of patient-physician contact. Home visits, where such relationships once were so easily made, are now relatively obsolete, due not so much to reluctance on the part

of the physician to make such calls, but more to the change in the nature of medical care. The patient with myocardial infarction is best treated not at home but in an area where facilities are adequate. Home deliveries leave much to be desired, and kitchen-table surgery is not now tolerable. Ambulatory lesions are best cared for in a physician's office. Contacts with the patient and his family in his home are thus becoming less, and the fertilization of compassion more difficult. These relationships are possible always, however, if the physician so desires.

But compassion must also be social as well as personal. However excellent our medical care and deep sympathy may be as it is applied to an individual, this is inadequate if that individual cannot reach a physician. No

one is better equipped to study this problem of distribution and to supply society with an answer than the physician. Yet here he has been most derelict, probably due to the lack of aggressive leadership. Local and state medical societies have given it very little attention, and medical schools, with the exception of a few outstanding ones in this respect, have been satisfied with verbiage or the appointment of committees. Perhaps we have now reached a point at which the answer to the question of inadequate distribution of medical care cannot best be solved by local medical societies and regional government and state agencies alone. It seems to me that it is the medical school that must take on this obligation of leadership in cooperation with the other groups, for it is the medical school to which we all must turn for the provision of such direction in all of its various accents.

The development of this leadership is not easy. We can see the way only in broad generalities. It is more than the physical act of building rural clinics. Social understanding is required — a broad background of humanism. For just as the breadth and depth of medical science requires intimate familiarity with the many facets of general science until its entire fabric is permeated, just so does a proper understanding of the humanism of medicine require deep knowledge of the story of human social development. This means knowing something of the early

struggle of society, the moral and social principles upon which it was formed. As we get to know how this society developed into larger and more complex groups, its laws, its culture, its ambitions and its dreams, we come to adjust the place of medicine in it with more wisdom. We can even relate it to particular areas with their particular problems. Here we need above all what Millis has called "the disciplines of the mind, the capacity to learn, the capacity to judge and the capacity to act rationally under a self-imposed discipline".

Obviously, such a background in the humanities for the student of medicine can never be completely achieved. Almost to the degree that the physician possesses it, however, will we be able to insert medicine into the social complex with great effectiveness. Unless this is done, we will find ourselves, in the provision of adequate medical care, static in a dynamic society. Such has already come to pass in varying degrees, and in allowing this to happen we are derelict. Unfortunately, just now I see little evidence that we are recognizing such a fault. Rather than broadening the base of the physician's education, there is a growing tendency to truncate this base to such a degree that sometimes it seems that literacy itself is under fire.

But perhaps all is not medicine's fault. The late Henry Sigerist once stated that the position of medicine at a particular time reflects best of all the culture of a society at that time. And this might well be

true today. The materialistic and mechanistic tendencies of our present society can well be seen in the education of our physicians and in the provision of medical care. An impersonal and computerized social structure is, it seems to me, being transferred into our medical education, our medical thinking, and thus into our medical practice.

Can a change in appreciation of values be brought about? Can medicine break through this environmental stricture? Even a brief study of the history of medicine shows that such has occurred on numerous occasions when medicine seemed to be imprisoned by the social structure surrounding it. Such has always required effort, however; effort on the part of individuals who can give strong and intelligent leadership, willingness and innovative productivity, and not just simply denigrative criticism.

We have already demonstrated that we can achieve well in the field of scientific inquiry, and progress here is continuing. But that broad field that I have called compassion has not yet been satisfied. And still it is a problem that lends itself to solutions, a problem whose solution becomes more urgent for medicine with the passage of time.

The image of the physician then remains an image of wisdom and compassion. It will, of course, undergo constant change, but always it will reflect the educational milieu to which that physician has been exposed and the cultural environment in which he must live.

There continues to be a great deal of discussion about the number of physicians needed for the United States and each of its constituent states. Spokesmen for the Administration in Washington express the view that the physician shortage will be ended by 1980, and strident and dissident voices across the land continue to debate the question.

Part of the problem is that the real expansion of medical education across the country and in North Carolina began right at the end of the decade of the '60's. Although individual voices had foreseen a need for increasing the production of physicians, there was no general enthusiasm for a major expansion in the 1950's or early 1960's, especially among the funding agencies. Since medical school requires three to four years, and training programs three to five years (training for family practice is now a three year program), and since there has been a two year obligation in the uniformed services for the graduates, the lag period from entry to medical school to entry into community practice has tended to range from seven to ten years. This means that the fruits of the recently undertaken expansion, in terms of increasing numbers of physicians to serve communities across North Carolina and the country, have not yet been felt.

As most of you know, the University of North Carolina School of Medicine at Chapel Hill has undertaken major expansion of its medical student

program during the past five years, and further expansion is planned for throughout the rest of this decade. In the 1968-69 academic year, we had a total medical student body numbering 287. In the current academic year, five years later, we have a student body of 471 students (including 20 first year students on the Greenville campus). By the 1979-80 year, we will have 640 medical students. Since similar expansion has occurred in schools across the country, and since a number of new schools have been built and are just beginning real productivity, the supply of physicians is expected to increase markedly during the next decade and a half. By a careful analysis of the various factors which constitute additions or subtractions to the pool of practicing physicians in the State of North Carolina, our present estimates indicate that we can expect the number of patient care physicians in our state to increase from slightly over 5,000 in 1974 to close to 10,000 by 1990. If present population projections hold, the growth in



the population of our state during those 16 years will be 15 percent or less.

At a more local and tangible level, some of our communities are experiencing improving success in recruiting the physicians they need. For example, Dr. Robert Cline recently reported that five new physicians are expected in Sanford this summer, embracing several of the needed specialties, including family medicine. It is our further anticipation that the Area Health Education Center Program, with its regional development of health education throughout our state, will contribute substantially to the number of physicians who settle in North Carolina, an increasingly helpful distribution geographically, and a sharply increased number of physicians training in areas of primary care, including family practice, general internal medicine, and general pediatrics.

The problems of access to medical services for all of the people of our state are not yet solved, and there are areas of substantial need this very day. But we are well on the way toward having a markedly increased supply of physicians over the next few years, and, at least in North Carolina, we have an approach to the problems of distribution.

Of chalk, classrooms, and clinics

David W. Ange has been appointed Assistant Professor in the Department of Radiology. Dr. Ange, who received both the B.S. and M.D. degrees from UNC-CH, has spent the last three years as a resident and fellow at M.D. Anderson Hospital and Tumor Institute.

John Wiley and Sons, Inc. has recently published "The Theory of Rate Processes in Biology and Medicine", by **Betsy J. Stover** of UNC, Frank H. Johnson of Princeton University and Dean Henry Eyring of the University of Utah. Dr. Stover is an Associate Professor of Pharmacology.

The Whitehead Society has honored **Dr. William Huffines**, Professor of Pharmacology and Associate Dean for Basic Medical Sciences. The citation read: "The Whitehead Society of the University of North Carolina School of Medicine would like to take this opportunity to

publicly thank Dr. William Huffines for the work he has done as chairman of the Educational Policy Committee. The EPC is a difficult committee to run at best because of its delicate balance of faculty, student and patient interests, all aimed for proper medical education and good medical care. Dr. Huffines has shown admirable dedication to the goals of sound curriculum planning and effective administrative organization of medical school affairs in the EPC as well as in his other capacities. He deserves public recognition of his devotion and effectiveness and we all hope he will be able to continue in his current work. We are fortunate indeed to have such a man working for the school."

William J. Arendshorst, has been named Assistant Professor in the Department of Physiology. He has been a part-

time lecturer and research fellow at the University since 1971. Dr. Arendshorst holds the B.A. degree from DePauw University and the Ph.D. degree from Indiana University Medical Center.

The North Carolina Chapter of the American College of Surgeons met in Chapel Hill from May 16 to 18. **George Johnson, Jr.**, Professor of Surgery; **Floyd A. Fried**, Associate Professor of Surgery; and **Robert L. Ney**, Professor and Chairman of the Department of Medicine, were featured on the program.

Floyd W. Denny has conducted studies that indicate that *Haemophilus influenzae* - - a frequent cause of respiratory and other illness in children and adults - - produces a toxic substance which may aid it in establishing infection. Dr. Denny, Professor and Chairman in the Department of

Pediatrics, did his work at the Clinical Research Centre in Harrow, England, under a grant from the National Institute of Allergy and Infectious Diseases.

Edward G. Rogoff has been appointed Assistant Professor of Radiology. Dr. Rogoff, who is a graduate of the University of Rhode Island and the State University of New York Downstate Medical School, is currently completing a two-year tour of duty with the Army Medical Corps. He has been stationed at the William Beaumont Army Medical Center.

Paul Munson, Kenan Professor and Chairman of the Department of Pharmacology, has been elected president of the Association for Medical School Pharmacology. He will head the organization of department chairmen of Pharmacology in the U.S. and Canada for two years.

Betsy J. Stover has been appointed to the fellowship review panel of the National Science Foundation. She will serve on the biomedical sciences panel, one of 12 panels that review fellowship applications. Dr. Stover is Associate Professor of Pharmacology.

The National Cancer Institute has awarded the School of Medicine \$137,202 for the study of certain rare genes which increase a person's susceptibility to malignant tumors and leukemia. **Michael Swift**, Associate Professor of Medicine, is the principal investigator.



A grant of \$142,414 from the National Heart and Lung Institute will enable a team of surgeons from the School of Medicine to study pulmonary circulation in patients undergoing open heart surgery. **Benson R. Wilcox**, Chief of the Division of Thoracic and Cardiovascular Surgery, is the principal investigator. He will be assisted in this research by **Norman A. Coulter, Jr.**, **Carol Lucas**, **Gordon F. Murray**, and **David Downie**, all of the Department of Surgery.

The National Heart and Lung Institute has awarded **Henry S. Kingdon** a five-year, \$235,699 research grant for the study of chemical changes that take place in the blood when it clots. Dr. Kingdon,

who is associated with the Division of Hematology, is Professor of Medicine and Biochemistry and Professor of Oral Biology in the Department of Periodontics at the School of Dentistry. **Gilbert White** will assist Dr. Kingdon in this project.

Rick I. Suberman has been named Assistant Professor in the Department of Radiology. Dr. Suberman holds the B.S. degree from N.C. State University and the M.D. degree from UNC-CH. He completed his internship and residency at The North Carolina Memorial Hospital and Duke University. Dr. Suberman is presently finishing a year's pediatric radiology fellowship at The Children's Hospital in Boston.

A \$436,310 grant from the Department of Health, Education, and Welfare has been awarded to the Department of Family Medicine. The money will be used to assist the family practice residency program. Department chairman **Robert Smith** said that more personnel will be hired and additions made to the family practice unit at The North Carolina Memorial Hospital.

The Department of Surgery's Trauma Section is conducting a \$330,000 study of the membrane oxygenator's use in treating people with traumatic injuries or a certain kind of pneumonia. **Herbert Proctor**, Associate Professor of Surgery and Chief of the Trauma Section, is principal investigator. UNC is one of nine medical centers across the country chosen for this study.

Mr. and Mrs. Calvin Kovens of Chapel Hill have given \$25,000 to the Department of Surgery to help support the research and teaching programs in peripheral vascular diseases. Department chairman **Colin G. Thomas, Jr.**, said that the gift is in appreciation of the medical care given their son, Scott Kovens, after he was injured in a wreck in the fall of 1973.

Edward Perl, Professor and Chairman of Physiology, has been awarded a two-year grant by the National Institute of General Medical Sciences for the study of acupuncture. He will test the ability of acupuncture to alter the sensations of touch, heat and vibrations as perceived through the skin.

James W. Woods, Professor of Medicine, has begun a study of two probable reasons why oral contraceptives produce or enhance hypertension in some women. He will also explore the link between hypertensive parents, their daughters and oral contraceptives. The research is funded by a \$20,072 grant from the Child Health and Human Development Institute of the National Institute of Health. Robert Elston of the School of Public Health is working with Dr. Woods on this project.

Joseph S. Pagano, Professor of Medicine, has been named Director of a multidisciplinary Cancer Center Program. One of 15 projected centers across the nation, the program involves people from the School of Public Health, Nursing, Dentistry and Medicine. Primary emphasis will be given to research, patient care, patient and physician education and public education through the Area Health Education Centers.

Leonard Palumbo, 53, Professor of Obstetrics and Gynecology, died in April at North Carolina Memorial Hospital after a brief illness.

Palumbo was a native of New York and had been on the

faculty of the UNC School of Medicine since 1952. He was also on the staff of The North Carolina Memorial Hospital.

He was a noted research scientist in the field of cancer of the female reproductive system and had published a number of papers on the surgical treatment of cervical cancer.

Palumbo earned his M.D. in 1944 at Duke University in an accelerated program. He also did postgraduate medical training at Duke and completed his internship and residency there.

From 1950 to 1952 he was an Associate in Obstetrics and Gynecology at Duke. He was a member of many professional organizations and was a diplomat of the American Board of Obstetrics and Gynecology.

He was a founding member and past president of the Southeastern Society of Obstetrics and Gynecology and past president of the South Atlantic Society of Obstetrics and Gynecology. He was also a member of the Robert A. Ross Obstetrical and Gynecological Society.

Surviving are his parents, Mr. and Mrs. Leonard Palumbo of Orange, N.J., one brother, Edward Arthur Palumbo of Northbrook, Ill., and two nephews.



Honors and Awards 1973-74

The Professor Award

James A. Bryan II, M.D.
Professor of Medicine and Family Medicine

The Medical Basic Science Teaching Award

James N. Weakley, Ph.D.
Assistant Professor of Physiology

The CCB Excellence in Teaching Award

Frederic G. Dalldorf, M.D.
Professor of Pathology

The Henry C. Fordham Award

Gordon Leigh Phillips, M.D.
Resident in Medicine

The Outstanding Intern Award

James Nello Martin, Jr., M.D. '73
1st Year Resident in Obstetrics and Gynecology

The William deB. MacNider Award

Richard Nixon Duffy III '76

The Isaac Hall Manning Award

Mary Catherine Dobbins '74

The James Bell Bullitt Award

David Robert Clemmons '74

The Medical Faculty Award

Thomas Welborn Bouldin '74

The Roche Award

David Earl Tart '74

The George C. Thrasher, Jr. Award

John Randolph Forehand '74

The Upjohn Award

Patrick Bowman Mullen '74

The Heusner Pupil Award

James Stephenson Wilson, Jr. '75

The Mosby Book Senior Awards

Terry Lyn Overby '74

David Thomas Taylor, Jr. '74

The CIBA Award

Wayland Wilson McKenzie '74

The Lange Senior Awards

Robert Martin Alsup '74

Charles David Collins '74

American Medical Women's Association

Scholastic Achievement Citation

Mary Catherine Dobbins '74

Suzanne VanHouten Sauter '74

Alpha Omega Alpha Honor Medical Society

Class of 1974

*Robert Martin Alsup

*Thomas Welborn Bouldin

William Griffith Bowen

William Edmund Bowman, Jr.

Douglas Carl Brewer

David Robert Clemmons

*Charles David Collins

Mary Catherine Dobbins

Margaret Ann Harper

*Terry Lyn Overby

Suzanne Van Houten Sauter

*David Earl Tart

David Thomas Tayloe, Jr.

*Daniel Castile Vinson

Max Lee Wallace, Jr.

William Grady Wilson

Class of 1975

Maynard Darvy Fuller, Jr.

Thomas Higgins

James Edward Peacock, Jr.

Hoke Dickinson Pollock

David Marshall Reid

James Stephenson Wilson, Jr.

Kenneth Howe Winter

*Elected Junior Year

The Student Research Paper Awards

The Deborah C. Leary Memorial Award

Joseph Majstoravich, Jr. '74

"Affinity Chromatography of Renin Using Inhibitory Renin Substrate Analogs"

Second Award

William Allen Richey '76

"A Morphometric Analysis of Lead Nephropathy"

The Third Award

Ronnie Gorman Swift '76

"Characteristics of Insulin Binding to Human Fibroblast Cultures"

The Student Research Day Awards

Student Research Day First Award

Joseph Majstoravich, Jr. '74

"Binding of Hog and Human Renin to Inhibitory Renin Substrate Analogs"

Student Research Day Second Award

Ronnie Gorman Swift '76

"A Practical and Reproducible System for Measuring the Binding of 125I-insulin to Cultured Human Fibroblasts"

Student Research Day Third Award

Harold Franklin Cable '76

"Quantum Mechanical Studies of Biologically Important Compounds: Adrenergic Amines, Chemotherapeutic Agents"

The Morehead Fellows, Class of '77

Evelyn Marion Bargmann

Francis Sellars Collins

Michael Stevens Wheeler





Foreign Fellowship Awards
 Earl Jackson Allison, Jr. '75
 Carl Alan Baum '74
 Jack Pool Byrd '76
 Harold Franklin Cable '76
 William Keith Hoots '75
 Thomas Warner Hudson III '75
 Henry Niles Nelson '75
 Charles Johnson Parker '75
 Michael Andrew Stang '75
 John William Uribe '76

AAMC/PHS International Fellowships
 Earl Jackson Allison, Jr. '75
 Carol Richmond Teutsch '75
 Larry Estel Warren '74

King Edward VII Hospital Fund - Duke
 Endowment Foreign Fellowships
 Claudia Peters Carbonetto '75
 Robyn Joan Dorsey '76
 Joseph Claude Feserman, Jr. '77
 James Benford Hardin '77
 David Carroll Henke '77
 Janifer C. Roberts '77

Warwick Fellowships
 Charles Henry Hicks '76
 Charles Vance Pope '76

The W. R. Berryhill Merit Scholarship
 Thomas Welborn Bouldin '74

The Riggins Merit Scholarship
 James Stephenson Wilson, Jr. '75

Alumni Merit Scholarships
 Terry Lyn Overby '74
 David Earl Tart '74
 Thomas Higgins '75
 Hoke Dickinson Pollock '75
 Richard Nixon Duffy III '76
 William Douglas Routh '76



Who's where

40's

Daniel Test Young, '48, has won the Thomas Jefferson Award for 1974. The award citation states, "Dr. Young excels as physician, cardiologist and teacher. He excels as well in matters of conviction." The professor of medicine at the UNC School of Medicine was honored for "an uncompromised sense of justice (that) is matched by a creative determination to find constructive solutions to wearing and occasionally explosive social problems." The award is given each year to a member of the University community whose life and activities "show the qualities of integrity and character that marked the life of Thomas Jefferson and which he would have recognized as essential to the political, religious and intellectual advancement of society."

William Neal Hubbard, '43, has been named President and Chief Executive Officer of the Upjohn Company of Kalamazoo, Michigan. Dr. Hubbard was formerly Professor and Assistant Dean at New York University and Dean of Medicine at the University of Michigan. He was most recently Vice President at Upjohn.

60's

William Swain Teachey, '68, is a major in the United States Army. He is stationed in Seoul, Korea, where he is chairman of the department of otolaryngology at the 121st Evacuation Hospital, Yongsan. Before entering the service, he was at the University of Florida in Gainesville for internship and residency training. He

married the former Donna Linder of Jacksonville, Florida, in March of 1973. Donna is teaching at the Women's University in Seoul while Bill is in the service. Their address is M-301 Riverside Village Apartments, Seoul, Korea.

Stewart Ellington, '69, has completed three years in the Navy. He returns to Salt Lake City, Utah, in July to complete a residency in internal medicine. Stewart is married to the former Janet Price. They have two boys - Stewart, 3, and Price, 6 months.

Henry M. Middleton III, '69, has joined the faculty of The Medical College of Georgia-Veterans Administration Hospital in Augusta. He is living at 3301 Thread Needle Court in Augusta. The zip code is 30907.

William B. Deal, '63, Associate Dean for Academic Studies at the University of Florida School of Medicine, has been elected to Alpha Omega Alpha. Each year the University of Florida Chapter elects one faculty member into the society. Dr. Deal was chosen for his outstanding contributions to teaching, medical research and patient care.

Donald P. Whitley, '65 has entered private practice as a radiologist in Richmond, Virginia. He is practicing with Radiology Associates of Richmond, Inc.

After three years in the Army, **Jim Wallace, '69**, is now in general surgery at Emory in Atlanta. He and his wife, the former Nicky Nicholson, were stationed in Germany for awhile. Jim plans to enter plastic sur-

ery. The Wallaces are parents of two girls, Monte, 5, and Sarah Spicer, 4.

John L. Davis, '69, completed ophthalmology training in Birmingham, Alabama, in January and is now in private practice in Atlanta. He is married to the former Ken Fischer. Their two children are Laurie, 6, and Walter, 2. John's address is West Paces Ferry Hospital, Atlanta, Georgia.

Jim MacNaughton, '69, spent a year in London in a surgical research lab. He is now back in Gainesville, Florida, to complete training in general surgery. He and his wife, the former Sandra May, have two boys — Robbie, 3, and Christopher, 1.

Don MacQueen, '69, finished pediatrics training in Charleston, South Carolina. He then studied pediatric allergy at the University of Florida for a year. Don is now in private practice in Wilmington. He and his wife Lynn are parents of a boy and a girl.

Following an internship in medicine at the University of Florida, **Dick Fleming, '69**, completed a two-year residency in internal medicine at the Mayo Clinic in July of 1972. He is now finishing the second year of a gastroenterology fellowship at Mayo. Dick will spend the next year at the University of California at Davis before returning

to a staff position at the Mayo Clinic in July of 1975. He and his wife Teresa have three children — Courtney, 5, Chad, 3, and Brooks, 6 months.

John Johnston, '69, is a pediatrician at the Odessa Brown Children's Clinic, a small neighborhood health center in Seattle. In August he and his family will move back to North Carolina, where John will be the fifth staff member of the Charlotte Pediatric Clinic. He completed his pediatric training at the University of Washington and then attended the School of Public Health in Berkeley, California. He and his wife Laurie have two children — Paige, 5, and Gardner, 2.

Ed Brenner, '69, writes, "Following graduation we moved to Silver Spring, Maryland, while I did a rotating internship at

Walter Reed General Hospital and Annette taught elementary school. The following year, Annette stayed on in Maryland while I went to Vietnam where I served as a General Medical Officer near the DMZ with the 101st Airborne Division. Following that, I began my residency in Ophthalmology at Letterman General Hospital at the Presidio of San Francisco, where I am currently Chief Resident, finishing in June 1974." Ed's tentative duty assignment for his final year in the service is the U.S. Military Academy at West Point. He will be Chief of Ophthalmology Service there. He plans to enter private practice by June of 1976. Ed and Annette are parents of a girl and a boy — Susan Elizabeth, 2, and Howard Benjamin, 1.

After his training in the



department of surgery at The North Carolina Memorial Hospital, **Andy Davidson**, '69, spent two years in the Navy at the Naval Air Station in Fallon, Nevada. He is now a resident in ophthalmology at the Wills Eye Hospital in Philadelphia. He and his wife Mary live across the Delaware River in Westmont, New Jersey, with their two children, Drew and Jeanne. Their address is 509 Fern Avenue. The zip is 08108.

Bill Stewart, '69, writes, "We spent two years in general surgery at the University of Rochester before coming 'home' to Boston, where I took another year of general surgery training at the Peter Bent Bingham Hospital before starting my urology residency there. I am currently on rotation at the Massachusetts General Hospital. In July I'll begin my year of chief residency after which I'll either go into the U.S. Army for two years or into practice here where we are living, north of Boston." Bill adds that he and his wife Dianna "blew the egg money" last summer on a 10 foot sloop. Both are looking forward to the races this year. Their children are John, 10, Mark, 6, and Bethany, 17 months. Home address: 42 North Shore Avenue, Danvers, Massachusetts.

After completing a straight surgery internship at Jackson Memorial Hospital in Miami, Florida, **Sam Cromartie**, '69, practiced anesthesiology during his two-year stint in the Army. He is now in his second year of general surgery residency at Jackson Memorial. Sam writes that he plans to finish his last two years of general surgery

residency at LSU in New Orleans. After that, he wants to begin a cardiac surgery residency. His address is 10740 Northwest 2nd Avenue, Miami Shores.

Jim Powers, '69, is on the teaching staff of Fitzsimons Army Medical Center in Denver. He has a joint appointment with the Clinical Research Service and the department of OB-GYN at Colorado University Medical Center. He plans to begin a fellowship in perinatal medicine at CU Medical Center in July of 1975, followed by a career in academics. Jim's wife, the former Pamela Hamilton of Washington, D.C., is "trying to be admitted to the entering Colorado University Medical School Class of 1975." Jim and Pamela have a daughter Jennifer, who is 3.

Cynthia Swisher McMillan, '69, is presently working in the Birth Defects Center at the University of Tennessee Hospital in Knoxville. She and her husband Bob, who works at Union Carbide in Oak Ridge, have a two-year-old son, Richard David, and expect another child in August. They live at 316 Heritage Drive East, in Concord, Tennessee. The zip code is 37720.

Ellis Fisher, '69, is practicing with a four-man pediatric group in Gastonia. He writes that they have just opened a 489-bed county hospital, "which comes at a good time." He also reports that the medical community is growing, but we "can always use more." He and his wife Meg live at 415 Jasin Drive in Gastonia. Zip code 28052.

Frank Tew and Bill Jordan both of the class of '69, are at the Naval Hospital in Orlando, Florida. Frank is "the cardiologist" in the five-man internal medicine department, and Bill is running the emergency room. Frank writes that Bill and his wife, who have a new baby girl, will probably move to Gainesville in a few months. Bill will begin a urology residency there. Frank would like to practice in North Carolina and is seriously thinking of applying to North Carolina Memorial for his final year of cardiology. His address is Apt. 292, 2500 Howell Branch Road, Winter Park, Florida 32789.

Russ Williams, '69, went to the University of Kentucky after graduation for an internship and residency in medicine. He's now an internist at Tripler Army Medical Center in Hawaii. He passed his boards in internal medicine last summer. Russ's address is 4999 Kahala, Apt. 268, Honolulu. Zip code 96816.

Robert W. Madry, '67, is now a cardiologist at the Medical Center Clinic in Pensacola, Florida. He and his wife live at 2695 Tambridge Circle. The zip is 32503.

70's
William H. Whisnant, '73, is doing a radiology residency at Vanderbilt. His address is 3621 Valley Vista Road, Nashville, Tennessee.

Fred Wolfe, '72, was in Chapel Hill for a short visit this spring. He is currently a resident at the University of Missouri.

“Two ‘M’s,’ a ‘W,’ and Modern Medicine”

James A. Bryan II, M.D.

Graduation Day! What a glorious time. I want to thank you for allowing me to participate in this day with you, and to share in the joy that comes on the fulfillment of a dream, the completion of a journey, and in the beginning of a new life.

Speaking at a commencement exercise is a new experience for me. What could I say that would let you know the affection that we of the faculty hold for you and the high hopes with which we send you out? You all know the usual costumes that we wear are white and our conversations involve patients, procedures and problems, but today is a time for memories, a time for mothers, wives and sweethearts, a time to review and renew promises and a time to think of the past as well as the future.

The costumes that we wear today come from the middle ages, with the colors, the robes, the hoods and the stripes identifying our schools, disciplines and status within academia. The format of these exercises has been constant, at least for the ten years that I have watched them and there is a sense of history

connected with all of this.

This matter of time and tradition and this role of history in shaping our behavior, our values and even our future has always fascinated me. The traditional references to Hippocrates and Mamonides are certainly appropriate on this day as they remind us that our peculiar discipline is to deal with humans that hurt, but it is sometimes hard to make old Hippocrates fit into the scene at Chapel Hill, the place where you have been introduced to medicine and where you have been inducted into the brotherhood. So, instead of talking about Hippocrates or quoting Sydenham or Osler, I want to talk about some people out of the past at this medical school.

These persons contributed greatly to the growth and character of this place from which you are graduating, and though each obviously reflected the particular times within which he lived, each life gives a clue not only to “how to survive” but also “how to contribute”. I want to thank Dean W. Reece Berryhill who supplied many of the sources for these sketches

and who is one of the real giants of this school.

You have all been members of the Whitehead Society, the name given the student body organization here. I want to first



tell you about Dr. Richard Whitehead. Dr. Whitehead was the first dean of the permanent medical school of the University of North Carolina. He was 25 years old when he came here as dean in 1890. He was the second choice of President Battle, who wanted to re-open the medical school and who wanted to recruit Dr. Paul Barringer, a physician-teacher who had started a basic science course for first year medical students at Davidson

College. President Battle and Dr. Barringer had worked out plans so that a special School of Medicine and Pharmacy could be opened in Chapel Hill with the University to supply some facilities. The University was to pay Dr. Barringer by collecting \$5 per year from each university student for medical care, and he was also to be the physician to the village. When Dr. Barringer went instead to the University of Virginia as Professor of Physiology and Surgery, he met young Richard Whitehead who was an instructor in Anatomy and who was from Salisbury, North Carolina. He recommended him to President Battle who offered Whitehead the job.

Dean Whitehead was actually re-instituting an effort in Medical Education at Chapel Hill. There had been a proprietary medical school from 1872-1879 run by Dr. Harris who abandoned the effort because of the lack of clinical material in the village. The school opened by Whitehead eleven years later continues today.

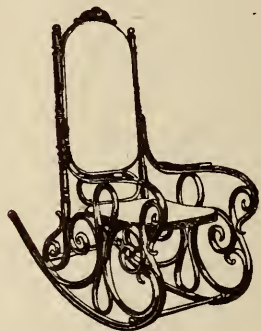
After Whitehead was offered the job, he delayed a year to get practical clinical experience at the hospitals in New York and Philadelphia, and then arrived in Chapel Hill in September of 1890 to greet ten students for the one year course.

Richard Whitehead was the son and grandson of physicians. He took a degree at Wake Forest College and then went to the University of Virginia where he received the M.D. after only one year of work instead of two. On arriving in

Chapel Hill he organized the medical school as a "Preparatory School of Medicine", acting as its Dean and Professor of Anatomy, Physiology, and Materia Medica. There were three other teachers in the school, drawn from the University, and the original course lasted only nine months. The course was designed to be preparatory to the diploma granting Medical Colleges with the students to be transferred to these latter schools. The school operated out of an office and lecture room in Old West with the anatomy dissections taking place in a little wooden building down in the woods where Venable Hall now stands.

Whitehead was the only full-time teacher and the school remained as a one-year school until 1895. The entering class that year was 25 in number and other faculty had been added. While these students studied, their Dean taught and practiced medicine in the University and in the community. He was known in the community as "the magic Dr. Whitehead" because of some clinical miracles he performed. One of his early cases is an example of his work and of medicine at that time. This was the case of a rather prominent Baptist minister who lived near Bynum, about ten miles south, down on the Haw River. The preacher had been sick for several days with nausea, fever, and severe pain and swelling in the right side of his abdomen. Whitehead was summoned and went in his buggy to visit the man. He made the diagnosis of appendicitis, which at that time

was called "locked bowels" or "cramp colic". He came immediately back to Chapel Hill to get a few instruments and pick up one of the medical students, then drove back. He made a small incision and inserted a long drainage tube into the swelling, placing the free end of the tube into a bucket by the bedside. The student, who later became Dean Mangum, told that the odor from the bucket was so foul that it could be detected from many yards and that buzzards came to sit in the trees of the preacher's yard. The minister recovered, however, and lived many active years - I suppose talking about Dr. Whitehead.



In addition to his clinical magic, Dr. Whitehead was an accomplished gardener, an inveterate user of the rocking chair and a master marksman with chewing tobacco. It was said that when he was lured away to become Dean at the University of Virginia in 1905, the first question he asked was "can you raise flowers there?"

Though we don't chew tobacco any more, in public, and though we don't handle

pendicitis in the same way,
the lessons to be learned from
Whitehead could include:

- Use rocking chairs.
- Love flowers.
- Choose your patients carefully - - i.e. find cases that will recover and have somebody around who can embellish the situation by telling a good story.

By the time that Dr. Whitehead left Chapel Hill in 1905, the Medical School had been formally incorporated into the University (1900), the course of study had been extended to two years, there were three full-time faculty members and the quality of the basic medical education available at Chapel Hill was well established in the clinical schools where the students transferred.

The next character sketch is of Dr. Isaac Manning, who had already joined the school as one of its full-time faculty. He had gone into medicine late (as some of you have), having been an industrial chemist and having received his medical education at Long Island University. When he came back to Chapel Hill in 1902, he had been a surgeon for the Atlantic Coast Line Railroad for two years. Although Chapel Hill was an isolated place, he already had roots there as his family had moved to Chapel Hill in the 1870's when his father - - a lawyer and former congressman - - joined the Law School.

Isaac Manning became Dean in 1905 (some said then that it was because President

Venable's wife was his sister), and he remained Dean until 1933. He was a quiet, steady man, working to make the school relevant to the Medical Education needs of his time and striving to enhance the image of the University by the quality of its product.

You must remember that during the years that he led the school there was much upheaval in Medical Education with the closing down of almost half of the Medical Schools in the country and a sharp decrease in the numbers of graduates. The state of North Carolina had no degree granting school until Duke University opened in 1930. Wake Forest had a preparatory school like U.N.C. The level of preparation for persons entering these schools was gradually increased from a high school diploma, to full college preparation only after the First World War.

During this time too, the

problems of getting enough physicians and getting them out of the rural areas started becoming a burning political problem. The Medical School here, although showing that more than half of its graduates remained in the state, was acutely aware of its dependency on the clinical schools of the North to complete the education of its graduates. Dean Manning was a one-man admission committee. By the late 1920's he chose the entering class of 40 from about 110 applicants. He determined who would be the future physicians in North Carolina by choosing the students he thought could compete for a place in the northern clinical schools.

Having outgrown its earlier facilities in Old West, the Anatomy Shack by Venable, and the little building down by Hill Hall where art is now taught, the school moved into the fine facilities of Caldwell Hall in



1912. The professors still were responsible for Student Health and still practiced medicine in the village. Of course, there was no hospital and when anyone required hospitalization they were taken to Watts Hospital in Durham. Because this place was so isolated and clinical opportunities were scarce, it was difficult to teach Physical Diagnosis and/or Introduction to Medicine. It was said that the course (taught by Dr. Lawson - - an ex-professional pitcher for the New York Giants, and on the University staff as Director of Physical Education) was so bad that the students would not attend. Dr. Manning's approach to this problem was to call in the student leaders to point out the necessity for the course and to use the ultimate weapon of any Dean - - no course - - no graduation. Does this sound familiar?

Dean Manning resigned as Dean after his decision not to admit a student to the school was overturned by Dr. Frank Porter Graham. He stayed with the school and continued to be active in medical care politics, actually organizing the Blue Cross-Blue Shield system in North Carolina in the 1930's to help meet the fantastic in-hospital costs of \$4 per day. Dean Manning is best characterized by his steadiness, his high standards, and his realization that the state University Medical School must be sensitive to the needs of the people of the state.

The third person I want to talk about also had a long and

distinguished connection with the school. His name was given to the main Medical School building, the one where you started your medical education. One of you received an award because your classmates thought you had some of the attributes ascribed to him, and during his life he was considered one of the bona fide characters of Chapel Hill.

As a matter of fact, Dr. Billy MacNider defined his life in Chapel Hill terms. He was one of Dr. Richard Whitehead's students, having gradually become interested in Medicine because of its connection with the natural sciences and because his grandfather Mallette had been a physician. When he was born in 1881, down on West Franklin Street on the site of Fowler's food store, Chapel Hill was a small village of 3,000 people and the University had around 1,000 students. His mother later ran a boarding house where the downtown post office is located and MacNider was always a student at the University from his earliest days. He earned money as a boy collecting specimens for the biology professor and gravitated to this field and later into Medicine by this route. After finishing the preparatory Medical School in 1899 in a class with 24 others, he went as far away as Raleigh to get his clinical training at the short-lived clinical school run by the University from 1902-1910, following which he immediately joined the faculty.

MacNider was a sparkler. In the modern vernacular we

would say he was a lover. He loved nature and studied it, he loved people, he loved patients, he loved his church, he loved his students, he loved flowers, he loved a taste of whiskey, he loved his family and he loved this school.

The expression of his life and all of this love - - energy was contained and made it possible because of the environment that he chose to work in. The boundaries of his daily life included his nearby home and family, his daily contact with the students through a daily lecture and lab, (and his open door reception of them at his home), and his nationally recognized scientific work in pharmacology and physiology.

Most of all, however, his life was supported by the community within which he lived - - the village of Chapel Hill and the University. To Dr. MacNider, the community was all of the people whom he knew so well and loved so much. Dr. Frank Porter Graham, the President of the University, talked about a night-long conversation he had with Dr. MacNider, as the latter tried to decide about an attractive position at the new, well-funded Vanderbilt Medical School. In deciding to stay at Chapel Hill, MacNider said "the MacNiders and Mallettes have been getting their milk from the Sparrows for the last 75 years and this is not time to change."

In these days, life will allow few of these humanizing situations. Who among us knows

the name of our milkmen or
farmers? I pray for each of
you a place where you can be-
lieve, and a place where you
can know the people.

Dr. Billy knew the people
and showed that he recog-
nized them by listening to them,
remembering their families,
visiting them when they were
sick, sharing the flowers from
his garden on East Franklin

Street, and living up to a saying
attributed to him: "There is
nothing in this world that costs
so little yet means so much as
thoughtfulness".

Ex-Chancellor House said
of him that he was "attuned to
every main value the University
stood for and was able to con-
vey to students the spirit and
feeling of what education was
all about. He had his own

unique way. For instance, in
the springtime he would say
to his class in Pharmacology:
"It is spring and this week-end
forget Pharmacology, send
some red roses to your girl, go
to church and worship God".

One day while performing
an experiment on a dog, he
turned to his students and
asked - - "What makes some
people so pompous?" Then
without waiting for an answer,
he said, "If I were asked what
is the first requirement for the
search of truth, I would say
humility, and if I were asked
for a second requirement, I
would say humility, and if I
were asked for a third require-
ment I would say humility" or
another aphorism, "Money is
refuse, it is the by-product of a
life spent in thought and
service.

Maybe the story of Dr.
Billy MacNider and his thoughts
on truth to a small group of
white, upper-middle class males
pursuing medical basis science
in a University located in a tiny
village has little relevance to
television trained, modern men
and women, but I have become
more and more impressed that
the lasting truth available to
us comes refined by time and
through the lives and characters
of the people that participate in
society's institutions, not in the
institutions themselves.

Innumerable others have
shaped the institution from
which you are graduating. May-
be some day you will have the
opportunity and fun of getting
to know them. Certain of these
people from the recent past
have been very important to



your experience as the enlargement of the school to an M.D. granting institution under Dean Berryhill, took place only 20 years ago. The first clinical chiefs such as Burnett, Wornack, Ham, Ross, and Fleming and the faculty they brought, plus the role that many others such as Mangum, Bullitt, Heusner, Welt, and Palumbo played in your own experience will be something for you to think about later on.

I hope that as I have presented these characters from the past at this school, I have been able to not only make some names that you have heard come alive, but that I could enrich the soil around your own lives. Your seed of Medicine was planted here at Chapel Hill at this school.

This school is the people associated with it, both those from the past and from the present, your classmates, your teachers, your patients, your preceptors, but most of all it has been you.

Your future "success and happiness", and ours, will be measured by your character and the particular factors that you choose to shape and discipline it. Maybe this intangible attribute, character, can best be approached through poetry.

Since I am not a poet, I have asked a friend of mine to prepare a poem for you. This is a man who joined the school last fall. Most of you don't know Dr. Marion Phillips, Assistant Dean for Student Affairs. Meet him as he joins me in closing these remarks to you.



The Twenty-Ninth Expedition

Dr. Marion Phillips

Something we are
that our minds have yet to discover
and yet to teach our tongues
to more than feebly stutter.
We're the very lungs of the storm
raging
raging
ambushing silence
before the developers fill in Walden Pond

And our vision survives
hurling both you and I
across the abyss of our disinherited youth

where, dispensing our mercies
we give the lovers of the world a second
and sometimes a third chance
to make a good first impression
upon us
before the world freezes to death
behind the walls of incense
erected by the altar boys.

With lit fuses of grandeur
crowning every sacred right
we bestowed upon ourselves
and for seasons watching them
hungrily selfconsuming somewhere
amidst holy chaos of altitudenous places.

Nothing vast enough can contain our vision
spilling over the sides of our age
seeking refuge permanently
among days of lively green trees
and ocean blue skies arresting a white sun.

We've intentionally invented something
that our minds have yet to discover
and yet to teach our tongues to more than feebly stutter, "Friend"
or maybe "Brother".

UNC Medical Alumni Bulletin
226 MacNider
Chapel Hill, N.C. 27514

Cut here and let us hear from you.

UNC Medical Alumni Bulletin
226 MacNider
Chapel Hill, N.C. 27514

Non-Profit Organization
U. S. POSTAGE
PAID
CHAPEL HILL, N.C.
PERMIT NO. 24

University of North Carolina School of Medicine



Hist. Rev.

The Bulletin's new format is now one year old. The contents it have been primarily the contributions of busy persons who are generous enough to take the time to write with style and spirit about the art and science of medicine. Almost everyone who has been asked to contribute has done so, taking pains to see that it was well done. Considering that there is no money in it and that it is yet to achieve the editorial recognition of, say, The New England Journal of Medicine, we find this helpfulness even more gratifying.

In the last issue, we focused on "The Good Doctor."

It seemed to us that after a philosophical consideration of such a topic, some nitty-gritty detail was in order. We were fortunate enough to have a chance to record the clinical "pearls" of 17 clinical teachers selected by the students. We think even the skilled practitioner will find some solution he or she had not thought of before.

Then Dr. Larry Churchill explains how UNC (among the first schools in the U.S. to do so) is undertaking to integrate the "humanities" into the medical curriculum. We think you will be interested in learning about how our students are learning to approach humanities in medicine.

Dr. Tony Cole, Visiting Instructor in Family Medicine, discusses how their program works... and the ironically happy twist is that they find that students can gain the confidence and cooperation of a family — so well, sometimes, that the family prefers the student to the staff doctor!

Dr. Charles Vernon acted as super-secretary for the Department of Psychiatry's Alumni Program honoring its first chairman, Dr. George Ham. You'll find some "pearls" in Charlie's report, too.

Now that you know more about what we're doing, let us hear about what you're up to.



Bulletin Advisory Board

William Blythe, M.D.

John Herion, M.D.

John Sessions, M.D.

Raymond Wheeler, M.D.

Nathan Womack, M.D.

Oscar Sapp, III, M.D.

Chairman, Ex-Officio Member

Katherine Lewis

Editorial Associate

Cheree Briggs, Editor

Credits

Photography by Maury Faggart

Design by The Design Group.

Gibbs-Wheeler Associates, Inc.

Bulletin: Vol.20 Fall Issue

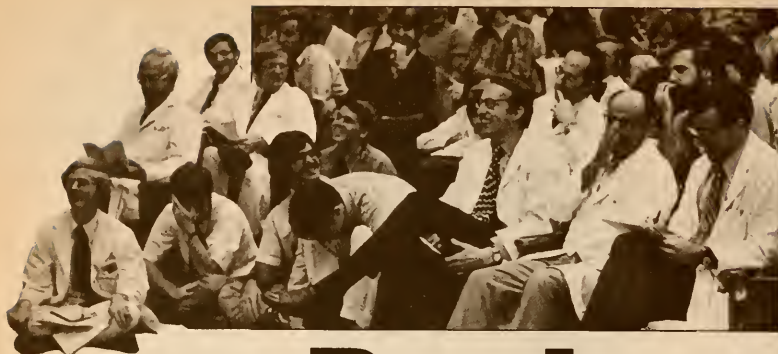
University of North Carolina School of Medicine

Table of Contents

One hour of pearls	4
126 MacNider	15
Confidentiality: Is it becoming a "science fiction" myth?	16
Of chalk, classrooms, and clinics	19
Dr. George Ham honored by hundreds	25
Who's where	27
What kind of doctor do you want anyway?	31

The Bulletin, of which this publication is Volume 20, No. 4, is published quarterly by the UNC Medical Alumni Association, Chapel Hill, N.C., 27514. Postage is paid by the non-profit association through U.S. Postal Permit No. 24.

One Hour of



Pearls

Editor's Note:

What IS a clinical "pearl"? It's one of those life-savers, time-savers or sleep-savers which allow the doctor to deal simply and directly with a medical problem.

The students took over one Monday's Grand Rounds and selected 17 of their teachers to give away their secrets. Each teacher had precisely three minutes to toss the knowledge gained the hard way to a standing room only audience.

A green light signaled, "go," and a student flashed a poster when 15 seconds remained. Then on came the red light. Although a couple of speakers finished breathlessly, every one of them made the deadline with the distillation of their collective know-how. It was proof, again, that learning can be a sell-out show as well as a lecture.

James A. Bryan

Professor of Medicine & Family Medicine

These pearls are from the area of primary care and have to do with comfort of the patient. They're very small pearls.

The first one has to do with something that will save you a night out when the old man calls you and says, "I can't pass my water." This is a very fundamental function, and when you're in the middle of the sack at 3:00 a.m. and he can't pass his water, you don't feel like going out to him or having him horse it into the ER. So what you say to him is, "John, go to the bathroom, draw a tub of hot water, get in it and pass your water." This works and he'll meet you in the morning. And then you can work on whatever the cause of this lack of ability to pass the water is.

That's one small pearl, and it has saved me three nights in the last fifteen years. And those are very important nights.

The second pearl has to do with the business of comfort during the awful situation when people's temperatures rise too high. The reason people's temperatures rise too high is because they shiver. They

shiver because they have bacterial problems or other problems. When interns and residents pour iced water, iced alcohol or throw them in an iced tub, this shivering continues. And this is not very much fun for people when they get thrown in there, being sick and being febrile. I urge you to remember this and to avoid the discomfort and reduce the shivering by using appropriate agents such as morphine. Remember this vasodilates, causes you to lose heat and is very effective in accomplishing what you want, namely to reduce the temperature.

The third pearl has to do with what I call "The Rule of the Vial." The drug manufacturers are smart enough to realize that we don't have time in an emergency situation to figure out the exact dosage of anything. In adult medicine we have the advantage of having this figured out for us and having an average sized dose put up in an ampule or vial. Therefore, when you're yelling for whatever you're yelling for — whether it's epinephrine, digoxin, calcium, sodium bicarb or whatever — you can say, "Give me a vial of ..." and that vial will end up being an average sized dose. This will save you a lot of time and looking up. Usually these kinds of situations call for that.



W. Paul Biggers

Associate Professor of Otolaryngology

My "pearl" for the Senior Class is in the form of an admonition—recurrent bacterial meningitis is secondary to a defective temporal bone, until proven otherwise, in the immunologically competent individual. The primitive endochondral bone that forms the permanent labyrinthine capsule is complete in its growth by mid-fetal life and has very unusual characteristics. It has very little propensity for healing after being fractured and affords little response to infection. It does not tend to put forth granulation tissue to wall off infection when invaded.

A second fact is that congenital defects of the temporal bone involving the inner ear and the partition between the inner and middle ear are much more common than previously thought. These defects are demonstrated with increasing frequency by sophisticated X-ray techniques such as hypocyclusoidal polytomography. By means of slides, I will demonstrate a common type of congenital deformity of the temporal bone. You must bear in mind that the cochlear aqueduct and the perilymphatic duct both lead to the meninges. In the pediatric age group, especially below age two, the cochlear aqueduct is often a freely communicating conduit to the subarachnoid space. Therefore, infection that gains access to the inner ear spreads rapidly to involve the meninges. As demonstrated, the congenital cystic dilatation of the cochleosaccular portion of the inner ear is called a Mondini defect. A communication often exists between the middle ear cleft and the congenital cystic defect through a defect in the medial partition or medial wall of the middle ear. Often the communication takes the form of persistent stapes-foot-plate fistula. Two such defective foot-plates recently removed at time of surgery

at this hospital are shown in the slides.

Because of the very poor healing potential of the endochondral bone of the labyrinthine capsule, fractures of the base of the skull may remain unhealed throughout the life-span of the individual. This lack of reparative response affords ready access for infection to spread from the middle ear and mastoid area through the unhealed defect in bone to the meninges. This unique lack of response to injury or surgery must be borne in mind as a careful history for trauma is elicited when dealing with recurrent bacterial meningitis. Most common organisms cultured from CSF in recurrent bacterial otic meningitis are pneumococcus, Hemophilus-influenza, and staphylococcus.

Thus I repeat my admonition—in cases of recurrent bacterial meningitis, one must think of the middle ear and mastoid air cell system as a likely infection source via a defect in the temporal bone. With the defect identified, effective surgical therapy can be instituted quickly, sparing the patient the ravages of repeated bouts of meningitis.



Dr. Robert Ney

Professor & Chairman of Medicine

One of the more interesting recent advances in the area of clinical endocrinology has been derived from the work of Dr. Ontjes and associates at this medical center. This work focuses on the early diagnosis of medullary thyroid carcinoma. As you know, this tumor secretes thyrocalcitonin. However, the radioimmunoassays for measuring thyrocalcitonin in the blood are not terribly sensitive, and therefore are not good enough for distinguishing normal from abnormal values in the baseline state. Therefore efforts have been

made to develop provocative tests that stimulate calcitonin secretion that might be useful in the early diagnosis of medullary thyroid carcinoma.

The work was originally based on observations carried out by Dr. Cary Cooper in the Dept. of Pharmacology who showed that a number of gastrointestinal hormones including gastrin and pentagastrin were capable of stimulating calcitonin secretion in experimental animals. In the pig, the thyroid venous effluent was collected and calcitonin was measured. As the pig was given increasing doses of synthetic pentagastrin, there were progressive increases in the release of calcitonin into the thyroid venous blood. These observations indicated that pentagastrin was a very potent stimulator of calcitonin secretion. Dr. Ontjes and his group then set about to examine the effects of pentagastrin on calcitonin secretion in patients who have medullary thyroid cancer.

They observed that in patients who had known, palpable medullary thyroid cancer, pentagastrin was a far more rapid and potent stimulator of calcitonin secretion than was calcium. With this data, they then sought to determine whether they could detect very early medullary thyroid carcinoma. They examined three teenagers (aged 14-17) from a family with known medullary thyroid cancer; none of these children had a palpable neck mass. These children had undetectable baseline plasma calcitonin values and when they were given a calcium infusion, there was no increase in their plasma calcitonin level. Only when these children were given pentagastrin was there a measurable rise in plasma calcitonin. I would remind you that none of these children had palpable neck masses, but each of these children underwent surgery, and were found to have microscopic foci of medullary thyroid cancer.

Although this tumor is rare (represents about 5-10% of all thyroid cancers), this represents a true advance in early diagnosis.



Ernest N. Kraybill

Assistant Professor of Pediatrics

I will describe recognition and management of three special problems of neonatal resuscitation occurring in the delivery room.

The first problem is depicted by the infant in the first slide. This is a full-term, normal-size infant who was in immediate respiratory distress with tachypnea retractions, cyanosis, flaring of nostrils. The clue to his diagnosis is the barrel chest and the scaphoid appearance of his abdomen. This set of circumstances should lead one to suspect a congenital diaphragmatic hernia through the foramen of Bochdalek. In this malformation abdominal viscera are located in the chest, usually the left hemithorax, and have compressed the heart, mediastinum and opposite lung.

In resuscitating this infant one should not ventilate with a face mask because doing so will force air into the gastrointestinal tract, distending the bowel located in the chest and further compressing heart and mediastinum. Instead, one should immediately perform endotracheal intubation and provide controlled respiration, remembering that the infant's tidal volume is reduced by at least fifty percent.

Diagnosis should be confirmed by x-ray and the infant taken to the operating room for immediate surgery.

The second problem is the infant whose amniotic fluid is meconium stained prior to delivery. Passage of meconium prenatally suggests fetal hypoxia. This most commonly occurs in post-mature infants whose placentas are beginning to degenerate and do not provide adequate support to the fetus

during labor. Such fetuses are especially prone to gasping during delivery and may aspirate meconium. Meconium then becomes impacted in the smaller airways where it forms an obstructive type of emphysema as well as a chemical pneumonia. The resultant respiratory difficulty may be fatal.

The physician conducting the delivery should have a section bulb syringe in hand and immediately and thoroughly suction the baby's nostrils, mouth and oropharynx as soon as the face is delivered, before the infant takes his first breath. After complete delivery of the infant and clamping of the umbilical cord the larynx must be visualized immediately by direct laryngoscopy and suctioning performed until the airway is completely cleared.

The third problem is presented by the infant who, following usual resuscitative measures including adequate ventilation and correction of acidosis, remains pale, limp and bradycardic. This situation may represent terminal asphyxia due to prolonged fetal hypoxia and if this is the case, no resuscitative measures are likely to be ultimately successful. However, a significant number of such infants are in hypovolemic shock due to placenta previa or cord accidents including compression which may prevent venous return to the baby while still permitting arterial outflow from the baby. The placenta provides an immediately available source of the baby's own blood which may be obtained and transfused. The technique is to suspend a placenta with the umbilical cord hanging dependently while an assistant inserts a large bore needle attached to a heparinized syringe into the umbilical vein and applies gentle suction. Any blood obtained in this fashion may be transfused directly via umbilical vein catheter, and may be given in quantities of 20-25 cc's per kilogram body weight. Both heparin and the Infusion Set containing the filter are stocked in our delivery rooms. Since this technique utilizes the baby's own blood, it requires neither requisition slip, crossmatch nor a charge to the patient.



James H. Scatliff

Professor & Chairman of Radiology

I'd like to share with you a "pearly" mnemonic about interstitial infiltrates in the lung. Basically there are two kinds of infiltrates that we see. They're either in the air-bags or alveolar spaces of the lungs or in the interstitial framework of the lungs. Interstitial infiltrates are difficult to diagnose and many times look like other lesions in the lung. A patient with diffuse, regular shadows which have produced what we call a honey-combed appearance of the lung might have Histiocytosis X or eosinophilic granuloma of the lung. At the other end of the spectrum is the patient who has a mottling throughout the lungs and actually has miliary tuberculosis.

As you see, it's difficult to think of the several possibilities that lesions like that create, so the mnemonic I'd like to give you is this one: When you're out of ideas about the CAUSES OF INTERSTITIAL INFILTRATES, try SCHLITZ (Just remember to square the "T").

Sarcoidosis - although classically involves the hilar regions with adenopathy, it may be just in the parenchyma of the lung.

Collagen vascular disease - particularly Scleroderma (produces honeycombing in bases of lungs).

Histiocytosis

Lymphangitic cancer - while we tend to think of metastases to the lungs as purely hematogenous, at times it may be only in the lymphatics - producing a reticular network.

Idiopathic lung fibrosis - most difficult of all; best example is the Hamman-Rich syndrome

Tuberculosis - must always think of miliary TB.

Tuberculosis - far-out entity, although this can certainly produce a reticular appearance.

Zilicosis (Pneumoconiosis) - to stretch a point.

When you're out of love, drink
miltz.



Colin G. Thomas, Jr.

Professor & Chairman of Surgery

The next 180 seconds will be devoted in their entirety to chronic (Hashimoto's) thyroiditis. The clinical importance of its diagnosis is related to the high incidence of thyromegaly in the general population, namely 2-4% of adults. I assume you have the ability to differentiate a thyroid nodule from other masses in the neck. Approximately 70% of thyromegaly is due to some form of adenomatous goiter. This may be manifested as a solitary nodule, multiple nodules, or a cyst. Clinical evaluation may provide little differentiation except for the presence of a second nodule or some enlargement of the opposite lobe. Thyroid scans are valuable in that they differentiate the hot nodule, the hypofunctioning nodule as well as the cold nodule. They must, however, be seen by the clinician and appraised in conjunction with the physical findings. A scan cannot per se identify a module. A cyst may appear as a cold or hypofunctioning nodule and can be identified

by ultrasound studies.

The second most common cause of thyromegaly, and one that is not usually appreciated, will be some form of thyroiditis. Hashimoto's thyroiditis accounts for 20-25% of thyroid disease. Both children and adults are subject to this problem. Usually there is little difficulty in differentiation since the entire thyroid gland is symmetrically enlarged. The initial presentation, however, may be that of an asymmetrical enlargement. Only after careful examination does one identify involvement of the opposite lobe. Diagnostic criteria include the following: (1) a positive family history, (2) a bosselated thyroid on palpation maintaining the configuration of the gland with both upper and lower poles being identified, (3) a discrepancy in the P.B.I. and T_4 levels greater than 27%, (4) and abnormal technetium scan with heterogeneous uptake of the isotope, (5) elevated thyroglobulin antibodies, and (6) a positive perchlorate flush test. Four of these six criteria being positive permit a clinical diagnosis which may be confirmed by needle biopsy. There are two other forms of thyroiditis. Subacute or granulomatous thyroiditis has a characteristic acute onset and localized tenderness which are almost pathognomonic. If the onset is insidious, however, with a hard but only slightly tender thyroid gland, the paradoxical findings of an elevated serum thyroxine and a depressed iodide uptake are distinguishing characteristics. Reidel's thyroiditis is not a clinical diagnosis and is indistinguishable from thyroid cancer.

There is no need to undertake partial thyroidectomy in Hashimoto's thyroiditis. The treatment is non-surgical consisting of replacement therapy with thyroid hormone. This (1) causes regression of the goiter and (2) ensures euthyroidism.

Edward H. Bishop

Professor of Obstetrics & Gynecology

I want to present a frequent and important, non-surgical, gynecological problem usually introduced by the patient by the statement: "Doctor, I have had constant pain in my right side for the past five years. I have seen four other physicians. None have helped me; they told me nothing was wrong." This represents a typical complaint of a large group of patients who are too often ignored. As a group, they present a typical profile. They usually are middle class, in the reproductive years, have multiple family and social problems, feel frustrated and are in a tenuous financial position. Their examinations are usually negative except for an impression of a low pain threshold with abdominal and pelvic tenderness of varying intensity.

The management of their problems is exceedingly difficult, and it is extremely easy for the physician to dismiss this patient after a cursory examination with treatment of an apparent psychogenic illness by the injudicious use of sedation and/or tranquilizers. Instead, it is obligatory to seek pathology or altered physiology by a thorough examination, not only of the genital tract, but also of the contiguous systems, the urinary and intestinal tracts. No evaluation is complete without cystoscopic and sigmoidoscopic examinations, x-ray evaluations of the urinary and lower intestinal tracts plus laparoscopic examination for evidence of genital pathology which may be neither visible nor palpable. Some evidence of either functional or structural abnormalities will be found in approximately half of these patients, but the physician should not succumb to the temptation of referring the remainder to a psychiatrist. The patient not only resents this transfer, but also unjustifiably may acquire stigmata of mental disease which often worsens rather than relieving the symptoms. Instead, one must achieve the confidence of the patient by listening to her problems, evidencing interest in her complaints while convincing her that every necessary investigative procedure has been performed. I think I could solve

the problems of those who do not respond to this approach by the use of a rather complex prescription made up of liberal doses of decreased home responsibilities, a lessened work load, increased vacation time, more income and the revitalization of a marital partner who is often disinterested and unsympathetic. The problem is that I know how to write the prescription, but I don't know where to send them to get it filled. Fortunately, the benefit of even such a minor social diversion as an occasional day out to visit the physician plus the opportunity to ventilate her chronic minor complaints before a sympathetic listener is often adequate therapy. However, I must warn you that if you are successful in your therapy, you may acquire an increasing number of patients of this type whose management may be so tedious that you in turn become a victim of chronic, continued, vague, unresponsive, non-specific lower abdominal pain.



Stanley R. Mandel

Associate Professor of Surgery

Pulmonary emboli are still the most common cause of death among hospitalized patients. In the treatment of thromboembolism, the most important aspect is prophylaxis, which should begin with recognition of the high-risk patient and with training the nursing staff in the measures that should be used routinely to prevent deep-vein thrombosis in all such patients. The prophylactic use

of dextran should be considered for all "bedfast" patients; and for high-risk patients, prophylactic coumarin or heparin is justified.

Once the diagnosis of pulmonary embolism is established, the intravenous administration of heparin should be begun immediately. Surgical procedures designed to prevent further emboli from reaching the lung should be reserved for patients who continue to have recurrent emboli after receiving adequate amounts of heparin, for those who have a massive embolus, or for those in whom anticoagulants are contraindicated. The advisability of using the Mobin-Uddin umbrella prophylactically is still to be determined.

The problem of thromboembolism is a grave and challenging one; its solution depends in large measure upon an aggressive team approach by the attending, resident, and nursing staff of every hospital.



Ardis Hoven

Clinical Instructor of Medicine

Cerebrospinal Fluid Changes in Diseases Which Must be Differentiated From Classical Bacterial, Mycobacterial, or Fungal Meningitis

Briefly:

You are familiar with the findings in acute bacterial meningitis. Tuberculous and fungal meningitis present classically with elevated protein (> 40 mgm%), moderate pleocytosis of 10-500 cells/mm³ predominantly lymphocytes, and a low CSF sugar in the range of 15-45 mgm%. In early tuberculous or fungal meningitis, the pleocytosis may be primarily polymorphonuclear.

SARCOIDOSIS

Opening pressure:	increased
Protein:	increased
Sugar:	may be decreased to the range of 15-40 mgm%.
Pleocytosis:	10-200 cells/mm ³ primarily lymphocyte

CARCINOMATOUS MENINGITIS

Opening Pressure:	increased
Protein:	increased
Sugar:	decreased
Pleocytosis:	up to 100 cells/mm ³ generally lymphocyte but PMNs may be the predominant cell type

Low CSF chloride is reported to have specific significance; however, acute bacterial and mycobacterial meningitis may also present with a low CSF chloride. The tumor types most likely to result in this entity include metastatic breast, lung, and gastric carcinomas, melanomatosis, gliomatosis, and diffuse infiltration of the meninges with leukemic or lymphomatous cells.

PRIMARY MENINGOENCEPHALITIS

flagellaria - the fresh water flagellate)
opening pressure: increased
protein: increased
sugar: decreased (may be quite low)
marked pleocytosis (up to 10,000 cells/mm³) predominantly PMNs: many RBCs

CHRONIC LUPUS ERYTHEMATOSIS

protein: increased, rarely over 100 mgm%
sugar: normal
pleocytosis: 50-100 cells/mm³ predominantly lymphocytes; however, cases of lupus meningitis have been reported in which the predominant cell was the PMN.

SPINAL ABCESS (without meningitis)

opening pressure: increased
protein: 45-200 mgm%
sugar: Normal
pleocytosis: 10% 5 cells/mm³
10% 500 cells/mm³

ly in the process, the cells in the
F are primarily PMNs; however, after
d encapsulation occurs, the cells may
predominantly lymphocytes. These
F findings may be identical to those
aseptic (viral) meningitis. Although a
normal sugar is seen in most viral CNS
fections, in lymphocytic chorio-
meningitis, mumps and Herpes simplex
fections the sugar may be decreased.
o to be remembered, during the early
ges of the viral infection, the cells in
CSF may be primarily PMNs. The
uses most readily cultured from the
F include ECHO, COXSACKIE, and
MUMPS.



Daniel T. Young

Professor of Cardiology

The American College of Cardiology puts on sessions of three days in cardiology, so I am going to give you three minutes.

Cardiology is a field in which the physical examination, as in neurology, is extraordinarily rewarding. I want to illustrate that by discussing a few things that could be learned by careful auscultation of the second heart sound and its immediate temporal associates.

In the first place, the diagnosis of atrial septal defect may be picked out from among all the many causes of non-specific pulmonic ejection systolic murmurs with considerable confidence by the fact that the second sound is widely and fixedly split in that condition and, leaving out certain very rare things, in no other. Thus it is possible to distinguish the atrial septal defect from the rather ubiquitous functional pulmonic systolic murmur.

In addition, the second sound is very helpful in distinguishing pulmonary valvular stenosis from atrial septal defect. In this case the second pulmonic component is delayed and sometimes faint but may be fairly loud and is not fixedly split as it is in atrial septal defect. The murmur itself may be entirely similar to that of atrial septal defect.

The second pair which may be distinguished fairly clearly by the character of the second heart sound is the cyanosis due to interventricular septal defect with pulmonary hypertension, or tetralogy of Fallot, sometimes a difficult distinction to make. In

ventricular septal defect with pulmonary hypertension, the second heart sound has two components, A2 and P2. P2 is fairly loud as seen here in the pulmonic area and is associated with a systolic murmur. In tetralogy of Fallot, on the other hand, the pan-systolic murmur may be the same as that of ventricular septal defect, but it is very rare to be able to hear the second component of the second sound at all because it is so faint as to be inaudible. That will distinguish those two entities with fair confidence.

The second sound and its immediate neighbor, the mitral opening snap, is of extreme importance in both the diagnosis and the detection of the physiologic state of patients with mitral stenosis. The opening snap, in the first place, is of diagnostic importance and may well be the only physical finding easily heard in mitral stenosis and should lead to a suspicion of that disease. Secondly, a lot can be learned about the physiology of mitral stenosis from the behavior of the opening snap. In severe mitral stenosis the opening snap may be close to the second sound, and in less severe stenosis it will be further away.

Judson J. Van Wyk

Professor of Pediatric Endocrinology

All of you can or should recognize florid thyrotoxicosis, particularly if severe ophthalmopathy is present; likewise, a neglected cretin with his pig-like facial appearance should be diagnosable on sight. However, how good are you at assessing the thyroid status of a patient with goiter, or a hyperthyroid patient receiving anti-thyroid drugs? When I ask most students to describe the cardinal findings of thyroid hormone excess or deficiency, they usually get flustered as they try to remember what the books say about some kind of specific changes in the hair, skin or fingernails. Forget these changes. I can't remember them either! Think catecholamines! Remember that the highest basal metabolic rates are encountered not in thyrotoxicosis but in pheochromocytoma! There is good reason to believe that thyroid hormone in some fashion acts through the

adrenergic system. A hyperthyroid patient is hypersensitive to norepinephrine and a hypothyroid patient is refractory to it. Van Wyk's 10 second office T_4 is obtained simply by laying the palm of my hand on the precordium to "feel" the cardiac output. An excessive thrust may be due to anxiety or thyrotoxicosis, but a quiet precordium is incompatible with a significant degree of hyperthyroidism.

The best test for hypothyroidism in childhood is an accurate measurement of height. Height will fall off long before obvious myxedema appears.

Doris, a spritely 8 year old, was treated with Lugol's solution for goiter beginning at age 8. (Lugol's is a no-no for goiter.) Serial school pictures revealed that she did not become grossly myxedematous until age 12 or 13, but growth records show progressive slowing from the time Lugol's was started.

Julia likewise progressively became transformed from a spritely 9 year old to an obese, ugly 15 year old. The onset of her hyperthyroidism was written in her growth chart and should have been diagnosed earlier. Several local physicians over the years had misdiagnosed her as being exogenously obese.

Conversely, a physician is often asked to conduct tests to see whether an obese child is hypothyroid or has some other endocrine disturbance. Most of these children don't need any lab tests at all, only a height measurement. Cushing's syndrome and hypothyroidism are invariably associated with severe attenuation of the growth rate, whereas exogenous obesity tends to stimulate linear growth. You can usually dismiss an endocrine cause of obesity in any child above the 50th percentile channel for height; conversely, a short obese child deserves closer scrutiny. A calculation of growth rate from 2 accurate measurements 6 months apart should confirm the single assessment of percentile standing.

Charles A. Herbst, Jr.

Assistant Professor of Surgery

The term CEA (Carcinoembryonic Antigen) was first proposed by Gold and Freeman in 1965 to describe an antigen found in extracts of the digestive organs of the human embryo and fetus.

It is a glycoprotein of about 200,000 molecular weight found in the glycocalyx of embryonic endodermal epithelium. An adult type antigen, termed Normal Colon Antigen, usually replaces CEA in the fetal colon during the third trimester. Even though this is not true 100% of the time, CEA that might be formed is normally excreted into the lumen of the colon, thus not being available for absorption by the vascular system.

There are two factors responsible for elevated CEA levels with gastrointestinal and other malignancies. First, the gene or genes responsible for CEA synthesis are expressed when cells undergo malignant change. Secondly, the glycocalyx containing the CEA antigen is exposed to absorption by the body because of interruption of the normal architecture.

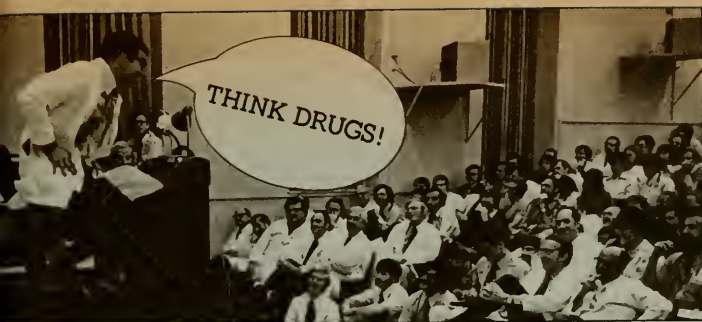
Initially it was thought that CEA was rather specific for colon carcinoma and would therefore be a good screening test. Recently, however, elevated CEA levels have been found with other gastrointestinal malignancies (pancreatic, primary or secondary hepatic, small bowel, and stomach), malignancies found outside the gastrointestinal tract (lung, ovary, cervix, uterus), and in gastrointestinal inflammatory disease (diverticulitis, ulcerative colitis, Crohn's, and pancreatitis). Thus, the value of the test does not lie in its screening ability, but rather as a serial test obtained post-treatment for evaluation of residual or recurrent disease.

Normal CEA levels are considered to be less than 2.5 nanograms per milliliter of serum or plasma. A nanogram is 10^{-9} of a gram. The only reliable method for determining amounts this small is radioimmunoassay. There are generally four different responses one might find associated with a malignancy. First, the preoperative CEA is normal and remains normal in the postoperative or post treatment period. This response

connotes a good prognosis. Evidence of this is presented in a recent article of the Journal of the American Medical Association, April 1, 1974 (Sorokin, Sugarbaker, Zamcheck, Pisick, Kupchik and F.D. Moore - Boston City Hospital) where 84 patients were reported with CEA levels consistently under 2.5 nanograms per milliliter who had no evidence of recurrent neoplasms. Fifty-six of these patients were followed for less than five years post-resection and 28 followed for greater than five years post-resection for their colorectal cancer.

A second response noted is a preoperative or pretreatment elevated CEA of greater than 2.5 nanograms which falls to within normal levels and remains normal throughout follow-up. In Archives of Surgery, August 1974 (Livingston, Hampton, Schuster, Gold and Hinchey - Montreal General Hospital, Canada) there was a group of 27 patients who had circulating CEA antigen preoperatively, and negative titers after resection for cure who were studied for a period of up to three years with negative CEA assays and no evidence of recurrent tumor. A negative postoperative CEA compared to a positive preoperative CEA does not, of course, completely exclude residual or recurrent tumors but certainly seems to carry with it a good prognosis.

A third serial response found is in those patients who have elevated CEA levels preoperatively or pretreatment which remain elevated postoperatively. These patients generally have residual disease, well documented in the two previously mentioned articles. The fourth response which carries the most exciting possibilities is in those patients who have elevated CEA levels preoperatively who initially become normal and then develop progressive elevation of the CEA level. This type of response connotes recurrent disease almost uniformly. In the JAMA article, there were six patients who had progressively rising CEA titers postoperatively, all of whom had documented recurrent disease. This should clue the physician into searching for recurrence in order to initiate chemotherapy, radiation therapy or surgery. Whether this earlier detection utilizing CEA will be beneficial remains to be seen.



Henry R. Lesesne

Assistant Professor of Gastroenterology

A potpourri. General Medicine. Two axioms from L. G. Welt:

"Observations not recorded are observations not made."

"All laboratory data not indicated are abnormal."

On diagnostic workups use Sutton's law — i.e., "Go where the money is." As you care for your patients, follow the Lord's command to Ezekiel in Ezekiel 3:15. Try to sit where your patients sit to see how they view their illness.

Gastroenterology. Places to look on a physical exam for metastatic cancer from the GI tract — Virchow's nodes, skin lesions (especially on the scalp — liver sized with nodules), Sister Mary Joseph's sign and rectal shelf. The surgeon should be sent on a blind date with hematemesis as seldom as possible.

Liver disease. When you see a jaundiced patient or abnormal liver function tests, THINK DRUGS. THINK DRUGS! Then think viral or alcoholic liver disease. ANY DRUG can cause liver damage. ANY DRUG! If you hear a liver friction rub, think tumor or cirrhosis. The best screening liver function test is a prothrombin time. If you get a comatose patient in on Saturday night when the labs are closed, get the coagulation technician in. That's your quickest and most sensitive test. SGOT and SGPT come from the liver and muscle. Therefore, get a CPK when you have elevated SGOT to rule out muscle disease. Alkaline phosphatase comes from the liver and bone primarily. Get a 5'

nucleotidase for differentiation as it comes only from the liver.

Viral hepatitis. Keep a close watch on hepatitis B-antigen. It has been found in the urine, saliva, sweat, breast milk, semen, joint fluid, feces and the mosquito. The hepatitis B virus is thought to be a venereal disease. You should all have your blood checked for hepatitis B-antigen to protect your patients. Fifty percent of people developing viral hepatitis never know it as they do not get jaundiced — they get a prolonged flu-like illness. If your patient has chronic active hepatitis and cirrhosis, be sure to rule out Wilson's disease, hemochromatosis or exposure to a drug or toxin as they are more readily treatable. Alcoholism continues to be one of America's biggest problems. Learn to spot the hidden alcoholic. Our problem is how to help the alcoholic stop drinking.

Our goals as physicians should be to cure sometimes, relieve often and comfort always.

Floyd W. Denny

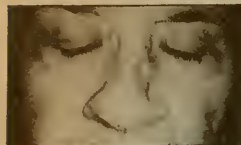
Professor of Pediatrics

My pearl today pertains to the management of uncomplicated upper respiratory tract infections, the most common complaint suffered by people in the United States. It has been estimated that the average person in this country has between 6 and 7 upper respiratory tract infections each year — the figure being much higher for children than adults. Keep in mind that we are discussing uncomplicated upper respiratory tract illnesses and not such things as otitis media, sinusitis, or cervical adenitis.

The first slide shows the causes of such infections. Many viruses — probably well over 100 separate strains — can infect the upper respiratory tract and are by far the most common cause of uncomplicated infections — probably in a ratio of about 20 to 1. *Mycoplasma pneumoniae* also can cause on occasion such infections. Among the bacteria *C. diphtheriae* can cause such disease, but in 1974 this is rare. The Group A streptococcus of course is a well known cause of respiratory infections and is important primarily because it can precede rheumatic fever and glomerulonephritis. The staphylococcus and gram negative bacilli are not capable of causing primary infections of the upper respiratory tract. The pneumococcus and *Hemophilus influenzae* probably do not cause uncomplicated primary illnesses, at least such have not been described. This leads me then to the next slide which depicts a rational approach to management of uncomplicated upper respiratory tract infections. When a physician is faced with a patient who is found to have involvement of the upper respiratory tract, the first thing that the physician should do is attempt to determine if this is complicated by such things as otitis media or sinusitis. If this is the case, then the patient must be handled accordingly. The much more likely event, however, is that the patient has an uncomplicated upper respiratory tract infection. In this situation, the next step is to determine if it is due to the Group A streptococcus, in which case treatment is essential for a variety of reasons but primarily to prevent rheumatic fever. If the patient does not have a Group A streptococcal infection, as far as we're concerned at this time no treatment is necessary and is contraindicated. Certainly there is no reason to treat viral infections because there is no effective treatment and antibiotic therapy can only invite secondary infections. *M. pneumoniae* infections of the upper respiratory tract are mild and self-limited and do not require treatment. With the exception of *C. diphtheriae* the presence of other bacteria in the upper respiratory tract represents only normal flora or an indicator of disease in other parts of the body or the response to antibiotic therapy.

Clayton E. Wheeler, Jr.

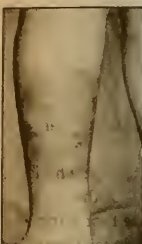
Professor of Dermatology



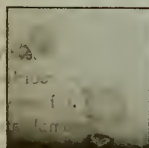
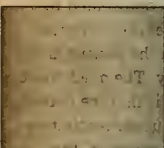
Lupus of the nose



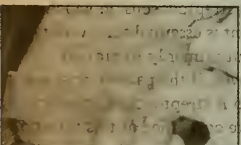
Impetigo of the lip



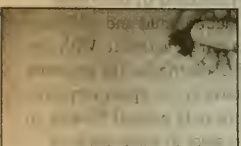
Stasis dermatitis



Streptococcal pyoderma Psoriasis



Whoops. I have lied to you. These were all superficial fungus infections which resembled the disorders mentioned. The best way to diagnose a superficial fungus infection is to scrape scales or blister tops onto a glass slide.



Run 10% KOH under the cover slip onto the scraping



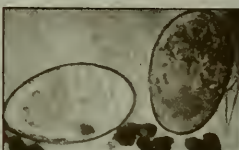
Heat gently over an alcohol lamp



Under a microscope one sees hyphae. Depending upon the organism and conditions there may also be spores



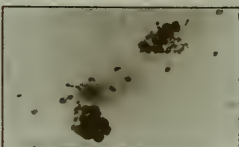
Pruritic papules of the penis and scrotum



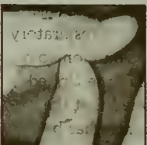
Deep scrapings show eggs and feces of the scabies mite — a diagnostic picture.



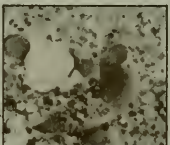
This woman has a chronic, generalized bullous disease.



Scrapings stained with Wright's show acantholytic cells characteristic of pemphigus vulgaris



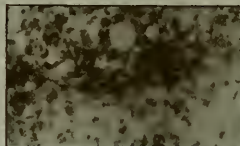
Grouped pustules on the thumbs



Scrapings stained with Wright's show viral acantholysis and giant cells characteristic of herpes simplex.



Scrapings from the edges of these necrotic areas showed ...



...on Wright's stain yeasts with large capsules characteristic of *Cryptococcus neoformans*

In addition, scrapings are useful in bacterial diseases and conditions with foreign bodies in the skin.

Examinations of skin scrapings is invaluable to the dermatologist and the various primary care physicians. It is simple, fast, cheap and often diagnostic. Who can afford to be without it?



Jeffrey Andresen

Assistant Professor of Psychiatry

I was giving a lecture to the first year medical students on Freudian psychoanalysis and decided there was a pearl to be passed on in the nature of a patient, whom I remembered. When I was in the Navy, I was assigned to Parris Island, South Carolina, where they make Marines. One night when I was the circuit rider physician taking sick call at the outlying dispensaries, I was sent to the women's

spensary where I came upon a young woman who was sitting looking very morose and preoccupied and in pain on a bench — there being nothing else to sit on at Parris Island.

The corps Wave who was there handed me a chart which was enormously thick for some soul on Parris Island for such a brief time. I picked it up and looked and saw that this woman had been in during her two weeks on Parris Island twice a day with complaints of abdominal pain and that she had been given the fruits of the finest researchers of the ethical drug industry and that her abdomen had proved absolutely adamant in resisting all this good medication.

So I asked her to come in and asked her how I might help her, and she described her pain as she had described it to my predecessors. I then asked her knowing actually what was happening) to tell me where her home was. She told me that she was from Maine and that she'd just come to Parris Island. I got her to describe in some detail what it was like in Maine at 9:00 on a Saturday night. As she recounted this, we got to the details of her father coming in from the farm — coming into the farmhouse to be given soup by the mother. I asked her where he hung his coat. She answered that he hung it in the hall, whereupon she burst into sobs. She said, "Oh, my God, I hadn't realized how homesick I was!" The abdominal pain was gone, and it did not recur during her time at Parris Island.

I have a pearl and a half for you from this, which is in many ways an utterly common kind of experience for a psychiatrist. The first pearl's half a pearl. It concerns this: her statement, "I did not know." When you ask a patient why they're doing something, you might keep this in mind if you expect that you're going to get the answer.

The second pearl that I have to pass on from this is: mind you, the human heart speaks several languages.

Edward Norfleet

— Assistant Professor of Anesthesiology

- I. Prevention of cardiac arrest in the hospital environment:
 - A. Observe and monitor closely any patient who recently has had an invasive diagnostic or therapeutic procedure. Be prepared to recognize and promptly treat complications; internal hemorrhage, intra-thoracic catastrophe, anaphylactic shock!
 - B. Avoid misuse of potentially dangerous drugs; understand their pharmacology; avoid errors in order writing!
 - C. Monitor monitoring devices, beware of electrocution!
 - D. Treat metabolic derangements aggressively!
 - E. Beware of tubular devices! Don't pull tubes at night! IV's — Subclavian, internal jugular lines - pneumothorax, hemothorax, mediastinal infiltration.
Endotrach tubes — misplacement, suction, kinks, plugs, improper humidification - hypoxia
N.G. tubes — misplacement in trachea with suction, feedings or drug administration - hypoxia and/or lung damage.
Swanz Ganz — cardiac arrhythmia.
Art Lines — never flush with more than 2 cc of fluid — clots to aortic arch — M.I. or stroke; beware of air bubbles.
Chest Tubes — check for proper function.
 - F. Understand the hazardous cardio-respiratory and metabolic effects of mechanical ventilation!
 - G. Understand physiological effects of massive blood transfusion, rely on physics for rapid fluid administration!
Large Bore IV's when you expect or experience massive volume loss: with abd. trauma, never rely on IV's in lower extremity.
Cold Blood Rapidly — temp.

rapidly to 28 °C — ventricular fib., hyperkalemia, acidosis, citrate intoxication! Use micropore filters to prevent iatrogenic pulmonary emboli.

- H. Mobilize early to prevent pulmonary emboli but beware of orthostatic hypotension in critically ill patients.
- II. When a Code 100 is called!
 - A. Can a team of 100 screaming medical personnel work more effectively than a well-organized team of five? (In a recent code we had a record for elevator attendance — 54 people, and yes, everybody pushed the wrong button!)
 - B. Has the patient really had a cardiac arrest? False alarm? STOP, LOOK and LISTEN! Is the patient breathing? Do you feel a pulse?
- III. A. B. C. D.
 - A. Airway
 - B. Breathing
Most important, frequently the cause of arrest, CNS depression — loss of upper airway reflexes — tongue becomes foreign body! Clear the pharynx, extend the head, lift the jaw! Oral airway most helpful, nasal airway excellent but often forgotten! Bags, mask, endotracheal intubation, learn them well, often ineffective and hazardous in inexperienced hands, use simplest method you know, mouth to mouth, nose to nose (enhance oxygenation with O₂ cannula in your own mouth). If the bag doesn't work disconnect, use mouth to mask. Look and Listen to chest, if methods fail, think of foreign body. When unable to obtain airway with endotracheal intubation, a 14 angiocath through the cricothyroid membrane with positive pressure ventilation may be a temporary lifesaving airway.
 - C. Circulation
Know and be able to locate the correct position for closed chest massage. Don't let your fingers do the walking through the rib cages! Use a firm surface, bed-board, food tray, floor! Use firm well-controlled pressure to displace the sternum 1 1/2 - 2 in, don't use jerky motions, keep hands

in contact with chest constantly! Use the right ratio/breath – 5 compressions, never interrupt for more than 5 seconds! One person should always monitor a femoral or carotid pulse constantly (compression of beating hearts causes tamponade)

D. Definitive Therapy

1. Diagnosis - search for cause of arrest, obtain any available history, lab data, use simple but constant physical exam! LOOK and LISTEN to the chest, feel the pulse, look for simple signs of perfusion, color, capillary refill! Evaluate neurological status, pupil reactivity, the "sign of the tear" (tearing during massage suggests good perfusion to the head). Suspect, look and listen for the many complications! A NG tube placed after intubation may prevent a ruptured stomach! With positive pressure ventilation, a pneumothorax is treated simply with a hole or tube into the chest (closed chest bottle drainage not immediately necessary.) Clues ask drug history – dig. – hypokalemia; ask disease process, renal failure, CHF, acidosis, hyperkalemia; what procedures were done today? What are electrolytes? EKG - PVC's, asystole, fibrillation, V-trach – frequently artifacts, look at patient, look and listen! Normal sinus rhythm - may be present without any cardiac output, feel or pulse. Treat V-trach quickly and aggressively!
2. I.V. percutaneous or cut down - ideal if working well and proper massage in process. Endotracheal tube 1 mgm epi in 10 cc H₂O, push down tube – absorbed rapidly (remember to remove syringe, needle – foreign body – lung) Tongue very vascular, close to heart, may be used for small volumes of drugs! Intracardiac many complications, use as last resort. If drugs produce

no action, ask are IV's infiltrated? Epinephrine – "rhythm and blues drug", produces a rhythm and cardiac output to do away with the blues! Historically most effective drug, may cause fibrillation, may convert fine fib to coarse fib, increases coronary artery perfusion by its action on peripheral circulation. Na bicarb "baking soda", treat metabolic acidosis, don't overalkalize, use ventilation to treat respiratory acidosis. CaCl and gluconate – CaCl contains 3x more ionized Ca than Ca gluconate, increases contractibility, useful in immediate treatment of hyperkalemia, incompatible with some drugs via IV.

Xylocaines – affects phase 4 depolarization, IV push 1mgm/kgm, overdosage – convulsions, treat with valium.

3. Defibrillation – Use saline soaked pads. (paste may cause short circuit across the chest, produce burns, make massage difficult) Use large dosage externally in adults. Don't shock your colleagues! I've been there, it smarts!

E. How long do we resuscitate? Every physician must make this critical decision after careful evaluation of all data! How long should we continue our heroic efforts in the bedridden 85 year old gentleman with terminal carcinoma?

Addendum Pearls for your internship!

With massive hemorrhagic shock or acute airway emergencies, don't waste precious time with fancy diagnostic procedures! A wise surgeon once said "An acute abdomen is like a game of poker, you can sit around all night trying to outbluff the opponent, but if you get up and look over his shoulder, you'll beat him every time!" (Dr. Nathan Wornack)

A wise anesthesiologist once said, "In medicine; do all those things we do know effectively and correctly, because God knows, we know so little!" (Dr. Kenneth Sugioka).

And the beat goes on!

We hope you like this new format of our Alumni Bulletin. I am grateful to Dr. Sapp, to the Editor, Miss Briggs, other members of the staff and to contributors for what I believe to be an increasingly interesting and informative publication to our alumni.

Ordinarily, this column is devoted to some component of the School's activities in an effort to be informative. On this occasion, however, I wish to issue an appeal to our alumni to give consideration as to how they can help us with one vital aspect of the School's work.

As most of you know, we are embarked and fully committed to a major statewide program in medical education, including collaborative efforts with the other health science schools in Chapel Hill, with the Bowman Gray and Duke Medical Schools, with an expanding undergraduate program on the Greenville campus and with Area Health Education Centers throughout the state. We have previously written of the anticipated impact of these programs on numbers of physicians and other health professional workers, distribution geographically and by specialty, the tremendous potential in continuing education and other key aspects of these programs. One of the real beauties of the statewide development is the potential it offers for improving the translation process: the translation of new developments in science and technology related to human biology and human disease from the basic medical sciences to the clinical sciences and from through-

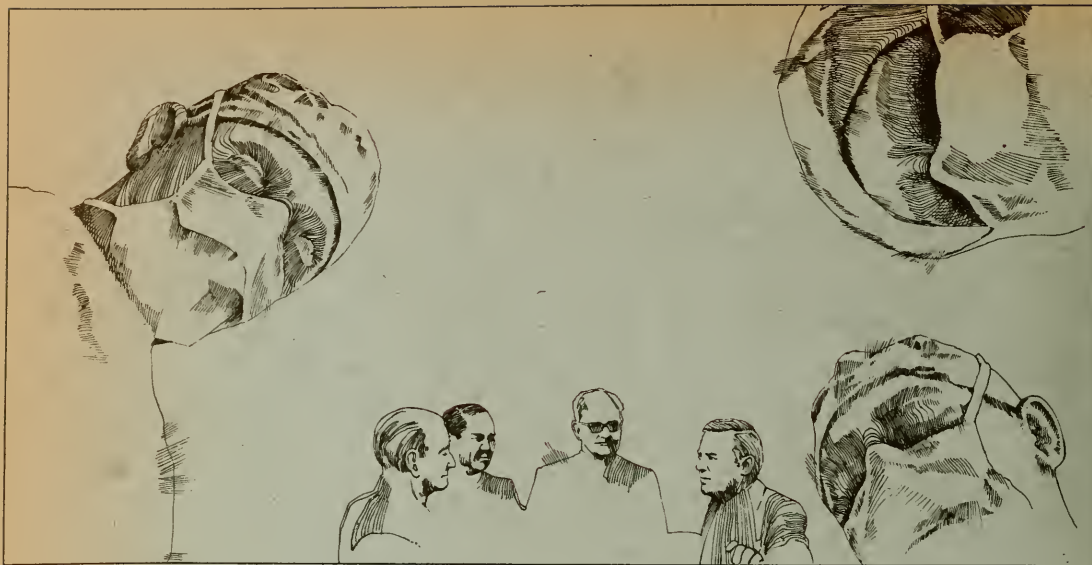
out the world to throughout the state. This is a vital function of the academic medical center and one which may be greatly enhanced in its usefulness through the statewide program.

In the context of this translation effort, the academic medical center must continue to generate new knowledge and understanding in the causes, diagnosis, treatment of human disease, from fundamental biology to applied therapeutics. In the face of increasing costs and declining federal support, the whole issue of biomedical research, its future contributions to the quality of life for our citizens and its integral role in the scholarship of the academic medical center, requires constant and vigorous attention and support.

I would greatly appreciate the consideration of the alumni in the establishment of a major research endowment at the School of Medicine. While I recognize that the alumni themselves will be able to make not more than modest contributions, especially in light of the contributions they are already making,

it may be possible for many of our alumni to stimulate major gifts and bequests from prominent citizens in their own communities to support this vital effort. Any thoughts, views or interest which any of you have on this critical issue would be greatly appreciated, and I know that Dr. Sapp and Mr. Emory Hunt would be most receptive to working with you in establishing and developing a major effort of this kind.





Confidentiality:

Is it Becoming a "Science Fiction" Myth?

Once upon a time probably about the year 380 B.C., on the island of Kos which nestles against the coast of what is now modern Turkey, a much-respected healer and teacher wrote down his thoughts concerning the principles of practice of his trade. This was not the first code of medical ethics but that which the sixty-year-old Hippocrates wrote has become the most famous and respected one and still serves much of the world as a medical "creed".

Now all this is legend, of course, but none the worse for that, and most physicians in

our Western culture would like to think that they still practice according to the tenets of the author of the Corpus Hippocraticum.

In his Oath, Hippocrates clearly states his belief in the importance of the physician's

respect for the patient as a trusting individual:

"... whatsoever I see or hear in my attendance on the sick, which ought not to be noised abroad, I will keep silence thereon..."

A little more than two millenia later this belief was reaffirmed in the Declaration of Geneva:

"I will respect the secrets which are confided in me..."

This mixture of historical fact and legend is leading up to some thoughts about the problems of reconciling the ideals of confidentiality with the ever-in-

creasing pressures of modern medicine.

All who are concerned with the practice of medicine, either as consumer or producer, are aware of the ethical problems which are highlighted in this era of accelerating technological advance. Organ transplantation, behavior modification, euthanasia, the use of "chronic" cardio-pulmonary resuscitative measures and many other aspects of late twentieth-century medicine challenge our traditionally held beliefs. In the sphere of confidentiality, problems are apparent in the area of data storage and retrieval by computer as well as in such matters as the dual responsibility faced by the school doctor or the physician who is employed by industry. The particular aspect that I wish to concern myself with here is that of confidentiality in the setting of medical education.

In a large measure, the particular problems which arise in both undergraduate and post-graduate teaching situations are similar to those caused by the increased size of the "health team" and the concentration on the importance of the written record. It can be appreciated that, in a medical practice serving its local community, the expansion of the health care team from the diad of "patient-doctor" to "patient-receptionist-records clerk-nurse-social worker-office manager-doctor" and the availability of the medical record to most of this group (except the patient!) can easily lead to, at the least, uncertainty for the patient as to how much may be "noised abroad". Add to this the increased likelihood of there being

some personal connection between the members of the medical staff and a significant percentage of the patient population plus the purely physical deficiencies of the practice facility in terms of soundproofing and the like, and one can see that our ideal of confidentiality becomes extremely difficult to live up to.

In the teaching situation these problems are compounded by the necessity for what may be lengthy and elaborate discussions of the "case" between teacher and taught. More particularly, in the field of family medicine, one is made aware of this when the concept that one wishes to get across is best exemplified by behavioral and psycho-social aspects rather than purely clinical ones. A paradox becomes evident here. While trying to instill these concepts, one is also faced with the necessity of exemplifying the concern of the family doctor with respecting the patient's confidence. In practice, I am constantly aware of the difficulty of keeping this ideal in mind while providing a satisfactory situation for student or resident. For instance, when dealing with a depressed patient whose illness has been brought on by the failure of her marriage, an important educational experience can be gained by the student from a discussion of those very personal details which the patient has given in confidence. However, to my mind, just as valuable a lesson can be given by showing the student that you do respect the patient's trust.

These apparent contra-

dictions can be reconciled, at least partially, and two main methods need to be employed. Of utmost importance, I feel, is to make sure that the patient is fully aware that a teaching situation exists and that the resident or student is introduced to the patient. Further than just introduction, my personal belief is that confidentiality can only be preserved if the patient looks on the "learner" as being as much a part of the health care team as is the "teacher".

Good evidence that this relationship can be easily established is found from our experience in a family medicine teaching program where it is not uncommon for a patient, having been seen initially by a teacher-learner duo, to ask for follow-up appointments with the learner. In one case that comes to mind, a fourth-year student followed a seriously depressed patient with frequent office visits through the course of a month when the patient's primary physician was unable to devote the necessary time to the problem. The result, in this case, was excellent, and no problems were found when the patient was returned to the physician because of the close understanding among the three people involved.

The second method that can be utilized in the struggle to preserve the patient's trust and privacy applies to that situation where there is discussion after the physician-patient encounter and where this discussion is between the doctor and those unknown to the patient. This method utilizes the concept of "primary" and "secondary" information and is

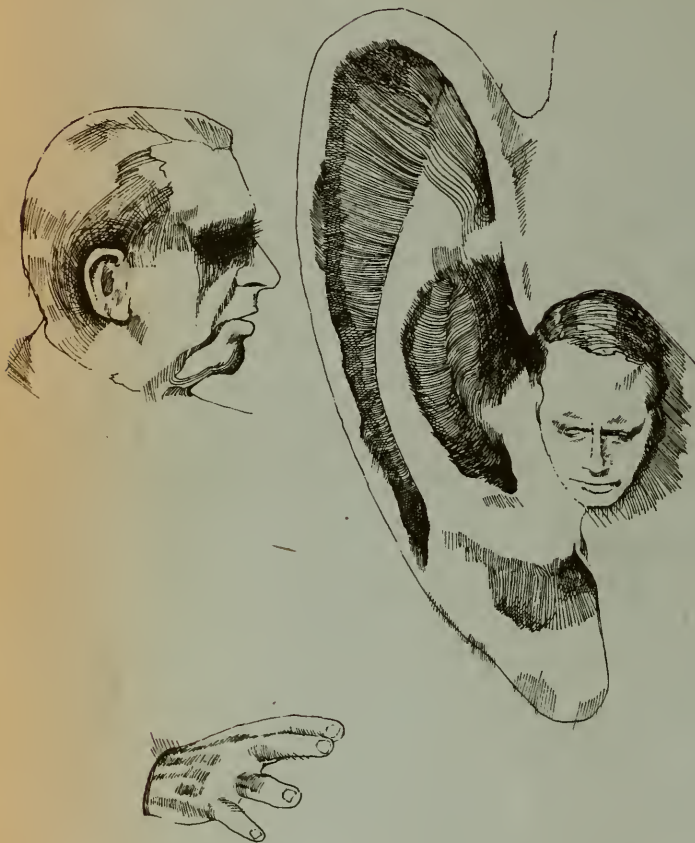
of extreme simplicity. The idea is that only that information which is useful to the discussion is imparted; this is called "secondary" and does not contain the more personal information

which allows the patient to be identified. Despite being a very simple idea, this is a more difficult method to put into practice. This is partly because of the more diffuse nature of the modern

health team and the wider availability of the record, but much more important it is difficult because of laziness and, I'm afraid, some lack of concern among those who have been entrusted with confidences. It is only too easy, when starting to discuss a patient's problems in a group of students or residents, to identify the patient by name and then go on to provide unnecessarily detailed information which is not of use in the context of that discussion.

Another example is provided by the family conference. This is an invaluable tool in the teaching of family medicine and consists of the presentation of a complete family history by the resident or student who has seen all members of the family both in the office and at home. As some members of the health team relate to this family, it is useful to have the input of the secretarial and other office staff. However, one has to be careful to avoid divulging unnecessary "primary" information which may not only violate the family's privacy but may cause embarrassment to those health team members who are personally acquainted with the family.

Confidentiality is the quality which is expressive of the nature of trust. In our modern world of almost "science-fiction" medicine, it behooves us to foster anew the trust our patients have in us and to impart this to succeeding generations with as much concern as the "father of medicine" had some two thousand three hundred and fifty four years ago.





Of chalk, classrooms, and clinics

Allen M. Feinberg has been elected a Diplomate of the American Board of Professional Psychology. The Diploma was presented at the Board's annual convocation in New Orleans on

September 1. Dr. Feinberg is Assistant Professor in the Department of Psychiatry.

Eng-Shang Huang, who has been a Visiting Assistant Professor for the past year, has

been named Assistant Professor in the Departments of Medicine and Bacteriology and Immunology. A native of Taiwan, he holds the B.S. and M.S. degrees from National Taiwan University and the Ph.D. from UNC.

Edward B. Glassman, Professor of Biochemistry, is the first elected president of the newly formed North Carolina chapter of the Society of Neurosciences. The statewide society is affiliated with the National Society of Neurosciences, an organization formed to bring together people from different disciplines who are interested in neurobiology. **Walter E. Stumph**, a Professor in the Department of Anatomy, is a Councilor.

John C. Hisley, Chief of the High Risk Pregnancy Service and Ultrasonography at the University of Maryland Hospital, has accepted a position as Assistant Professor of Obstetrics and Gynecology. He is an alumnus of Washington and Lee University and received the M.D. degree from the University of Maryland.

Philip T. Johnson has been named a Diplomate of the American College of Laboratory Animal Medicine. He is Campus Veterinarian for the Department of Laboratory Animal Medicine and an Instructor in the Department of Pathology.

Clayton E. Wheeler, Jr. was elected president of the Society for Investigative Dermatology at its annual meeting in Chicago in June. He is chairman of the Department of Dermatology.

Henry T. Frierson, Jr. has been named Assistant Professor in the Department of

Family Medicine. He holds both the B.S. and the M.Ed. from Wayne State University and has just completed work for the D.Ed. degree at Michigan State University.

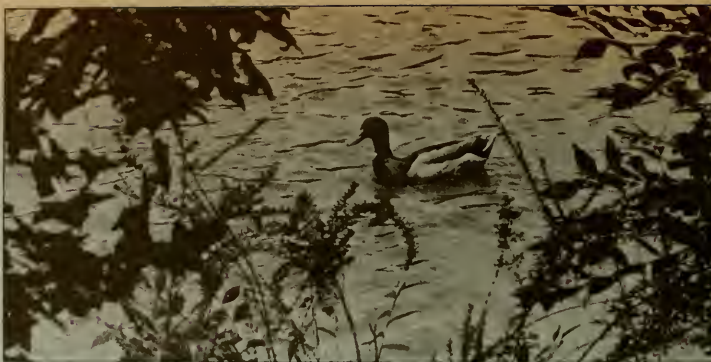
Hector Farias, Jr., Assistant

Professor of Family Medicine, has been named executive director of Choose Health, Inc., a program in Laredo, Texas, designed to plan, develop and establish effective continuing and progressive health education and training programs.

Judson J. Van Wyk,

Chief of the Division of Pediatric Endocrinology, participated in the Nobel Symposium on "Somatomedin and Some Other Growth Promoting Factors", held in Stockholm in September. While in Europe, he also spoke at the University of Oslo in Oslo, Norway, and at a meeting of the European Society of Pediatric Endocrinology in Paris.

H. Stanley Bennett, co-chairman of the U.S. - Japan Committee on Scientific Cooperation, was awarded the Second Class Order of the Sacred Treasure by the Japanese Ministry of Education in Tokyo in June. The medal, which is the second highest award in Japan, was presented by the Japanese Minister of Education. It was given to Dr. Bennett in recognition of his contributions to Japan - U.S. scientific development through teaching a number of Japanese scholars in his laboratory. He is Sarah Graham Kenan Professor of Biological and Medical Sciences, Chairman of the Department of Anatomy and Director of the Laboratories for Reproductive Biology.



Stephen H. Gehlbach, a graduate of Harvard University and the Case Western Reserve School of Medicine, has been appointed Assistant Professor of Pediatrics. He has just recently completed work for the M.P.H. degree from UNC.

Silas B. Coley and

Barbara James participated in the second annual Beach Summer Workshop at Myrtle Beach, S.C. It was sponsored by the Divisions of Continuing Education at Bowman Gray, Duke, Medical University of South Carolina, and UNC. Dr. Coley spoke on depression and Dr. James spoke on marriage counseling. Both are Assistant Professors of Psychiatry.

Charles W. Carter, Jr.

has been appointed Assistant Professor in the Departments of Anatomy and Biochemistry. A graduate of Yale University, he received both the M.S. and Ph.D. degrees from the University of California at San Diego. Dr. Carter has just completed a year's postdoctoral fellowship at the Medical Research Council Laboratory for Molecular Biology at Cambridge University, England.

Louis E. Underwood, Assistant Professor of Pediatrics,

has been selected the Jefferson-Pilot Fellow in Academic Medicine for 1974-75. The award, which was established three years ago by the Jefferson-Pilot Corporation, provides the recipient with \$2,000 per year for four years. Dr. Underwood, whose main research interest is the hormonal factors controlling growth, plans to use the fellowship money to study cell culture techniques.

William J. Cromartie,

Associate Dean for Clinical Sciences, has been elected chairman of the Board of Governors of the American Academy of Microbiology. He will hold the position until June 30, 1975. The Academy is the major professional organization of microbiologists in America and is responsible for a variety of professional activities in such fields as clinical and public health microbiology. A limited number of microbiologists are nominated for fellowship in the Academy each year. There are approximately 800 members in the Academy.

Members of the Robert A. Ross Society and the medical societies of New Hanover,

Brunswick and Pender counties met in Wilmington September 21 to hear **W. Reece Berryhill**, Dean Emeritus, deliver the Joseph Ward Hooper, Sr. Memorial Lecture. The title of the address was "The University and the Community."

Enid Kafer, Associate Professor of Anesthesiology, has received a \$65,000, three-year grant from the National Heart and Lung Institute to study how the respiratory system adjusts to increased workloads.

Thomas B. Barnett, Professor of Medicine; **Floyd W. Denny**, Professor and Chairman of Pediatrics; **Gerald W. Fernald**, Associate Professor of Pediatrics; **Ernest N. Kraybill**, Assistant Professor of Pediatrics; and **William C. Sugg, Jr.**, Clinical Assistant Professor of Medicine, will participate in the second North Carolina Postgraduate Course on Pulmonary Disease. The course will be held in Raleigh December 5 and 6.

Lee O. Stang has been appointed Assistant Professor in the Division of Physical Therapy. She has been director of Physical Therapy Services with the South Carolina Department of

Home Health and Environmental Control since 1972. A graduate of the University of Massachusetts, she earned the Certificate in Physical Therapy at Columbia University College of Physicians and Surgeons and the M.P.H. from UNC-CH.

Robert E. Cross is a newly appointed Assistant Professor in the Departments of Medicine, Biochemistry and Nutrition and Pathology. A postdoctoral fellow at the University since 1972, he will also serve as Associate Director of the Clinical Chemistry Laboratory. He holds the B.S. and M.S. degrees from the University of Toledo and the Ph.D. degree from the University of Florida.

Laurence Ray McCarthy has been named Assistant Professor in the Departments of Bacteriology and Immunology and Pathology. He comes to the University from the Memorial Sloan-Kettering Cancer Center in New York, where he was Associate Director of the Diagnostic Microbiology Laboratory. A graduate of St. Anselm's College, he holds the Ph.D. degree from the University of New Hampshire.

Gerhard W. D. Meissner has been appointed Assistant Professor in the Departments of Biochemistry and Nutrition and Physiology. A recipient of the B.S. and M.S. degrees from the Free University of Berlin and the Ph.D. degree from the Technical University of Berlin, he has been a Research Assistant Professor at Vanderbilt University since 1972.

Elliot M. Puritz is now practicing dermatology in Smithtown, New York. His office is in the Smithtown Executive Plaza,



222 East Main Street, Smithtown 11787.

Donald E. McMillan, Associate Professor of Pharmacology, is the author of a textbook, "Central Nervous System Pharmacology: A Self Instruction Text," published recently by Little, Brown and Company. The programmed text on the effects of drugs on the function of the central nervous system was field tested at four medical schools in addition to the UNC Schools of Medicine, Dentistry and Pharmacy.

Morris A. Lipton testified in July before a Senate committee investigating treatment of children of military personnel at a federally funded Florida psychiatric center. Then, in September, he traveled to Gottenger, Germany, to meet with 25 of the world's leading molecular biologists to examine the influence of genes and biochemistry on mental illness and normal behavior. He is Professor of Psychiatry and Director of the Biological Sciences Research Center of the Child Development Institute.

O'Dell W. Henson, Jr.

has joined the faculty as Professor of Anatomy and Surgery. He holds the Bachelor's and Masters degrees from the University of Kansas and the Ph.D. from Yale. Since 1964 he has been a member of the Department of Anatomy at Yale.

David D. Metz has been appointed an Assistant Professor of Hospital Administration with primary responsibility in the AHEC capital development program. He will also serve as liaison for the Greensboro AHEC. Prior to coming to the University, Mr. Metz was Assistant Director of the Beth Israel Hospital in New York and Administrator of the Ambulatory Health Services of the Medical Center. A graduate of Queens College of the City University of New York, he holds a graduate degree in Health Care Administration from New York University.

Lynda Darr and **Woodruff** and **Karen Joyce Yundt** have been named Instructors in Physical Therapy. Ms. Woodruff, who holds the M.S. Degree from Case Western Reserve University, comes to Chapel Hill from Danville, Virginia, where she was a staff physical therapist at Memorial Hospital. Ms. Yundt received her degree from Duke University and has been associated with the United Cerebral Palsy Association in New York.

Philip M. Blatt has joined the faculty of the Department of Medicine as an Instructor. A graduate of the University of Pennsylvania and the Washington University School of Medicine, he received his intern and residency training at the North

Carolina Memorial Hospital. He has also been a Postdoctoral Fellow in Hematology at the University of Utah and a Postdoctoral Fellow in Coagulation at UNC-CH.

William F. Finn, a Postdoctoral Fellow in Nephrology for the past two years, has been appointed Assistant Professor of Medicine. A graduate of Le Moyne College and S.U.N.Y. College of Medicine, he spent a year doing work in nephrology at Ohio State University before coming to Chapel Hill.

John T. Gwynne, who worked in the Clinical Endocrinology Branch of the National Institute of Arthritis, Metabolism and Digestive Diseases for the past two years, has been named an Instructor in the Department of Medicine. He received the B.S.E.E. degree from Princeton University and the M.D. degree from Duke University Medical School, where he completed internship and residency training.

Nortin M. Hadler, a graduate of Yale University and Harvard Medical School, is a newly appointed Assistant Professor in the Department of Medicine. After serving as Clinical Instructor in Medicine at Georgetown University Medical School and Senior Resident at Massachusetts General Hospital, he spent a year in Harrow, England, as a Visiting Scientist at the Clinical Research Centre.

Eugene P. Orringer, who first came to The North Carolina Memorial Hospital as an intern in 1969, has been named an Instructor in Medicine. He has

been a Fellow in Hematology for the past two years.

Felix A. Sarubbi, Jr. has joined the faculty as an Assistant Professor of Medicine. A graduate of Manhattan College and the New York University School of Medicine, he was an intern and resident at The North Carolina Memorial Hospital. Since 1972 he has been a Research and Training Fellow in Infectious Diseases at UNC-CH.

Peter D. Utsinger, a graduate of Le College de L'Assomption in Worcester, Massachusetts, and the Georgetown University School of Medicine, has been appointed Assistant Professor of Medicine. After receiving his internship and residency training at The North Carolina Memorial Hospital, he spent a year as a Research Fellow in immunology and a Clinical Fellow in Rheumatology at the University of California at San Diego.

Neil Allen Hoffman has been appointed Assistant Professor in the Department of Pathology. He will also be Associate Chief Medical Examiner for North Carolina. He received the M.D. degree from the University of Wisconsin and completed his residency in Forensic Pathology at Case Western Reserve University. He then received residency training in Anatomical Pathology at Washington University in St. Louis, Missouri. For the past two years he has served as Chief of the Pathology Service at U.S. Lyster Army Hospital in Fort Rucker, Alabama.

Herbert Asel Cooper has received a joint appointment as Assistant Professor in the Departments of Pathology and Pediatrics.

Robert E. Gould has been named Chief Resident and Instructor in Pediatrics. A graduate of Case Western Reserve School of Medicine, he completed his internship and residency at The North Carolina Memorial Hospital. A resident and trainee in the Department of Pathology until his appointment, he also received residency training in pediatrics at the Mayo Graduate School of Medicine. Dr. Cooper is a graduate of the University of Kansas School of Medicine.

Robert G. Dillard is a newly appointed Assistant Professor in the Department of Pediatrics. He is a neonatologist and will be located at Moses Cone Memorial Hospital in Greensboro. A graduate of the Yale University School of Medicine, he completed his pediatric internship and residency at the University of Tennessee Medical Units, where he subsequently served as Chief Resident and Neonatology Fellow. He has

been a pediatrician with the U.S. Army for the past two years.

Barry Goz, Associate Professor of Pharmacology, comes to UNC from the Yale University School of Medicine, where he has been an Assistant Professor of Pharmacology since 1967. He received the Ph.D. degree at the State University of New York Downstate Medical Center and did postdoctoral work at Yale.

Paul J. L. Bessou has been appointed Visiting Professor of Physiology for six months. He received his education from the Faculte de Medecine, Toulouse, France, where he is currently Professor and Chairman of the Department of Physiology.

Miklos Rethelyi has been appointed Visiting Associate Professor of Physiology. He received the M.D. degree from Pecs Medical University in Hungary and is currently Senior Assistant Professor at Sommelweis University Medical School in Budapest. He is internationally known for his work on the development and structure of the central nervous system.

William B. Hunter has joined the faculty of the Department of Psychiatry as an Instructor. He received the M.D. degree from the University of Washington and completed his residency at The North Carolina Memorial Hospital where he has also been a Fellow in the community psychiatry program. He has been assigned to the inpatient service.

Michael W. Stannard from Southampton, England, is a Visiting Assistant Professor in the Department of Radiology. He received his medical training at the London Hospital Medical

College and at Southampton University Hospital.

Michael L. Stewart has been appointed Visiting Instructor in Radiology. A graduate of the University of Texas and the University of Texas Medical Branch at Galveston, he interned at Brackenridge Hospital in Austin. He had one year of radiology training at St. Vincent's Hospital in Bridgeport, Connecticut, and two years at the V.A. Hospital in Dallas.

Gilbert W. Turner is a newly appointed Research Associate and is on the teaching staff of the Radiology Technology School. A graduate of Elon College, he received his radiology technology training at UNC-CH. He has a joint appointment with the Department of Medical Allied Health Professions.

Margaret Ann Nelson has been named a Research Associate in Surgery. She received the B.A. and M.D. degrees from George Washington University. After serving an internship at the University of Virginia Hospital, she continued graduate studies in surgery at UNC-CH, where she has been a Clinical Cancer Training Fellow since 1971.

Timothy N. Taft, an Instructor in Orthopaedic Surgery, is a graduate of Princeton University, where he was a USPH Fellow in Pathology. He completed his internship and residency at The North Carolina Memorial Hospital and was named the Womack Scholar for 1974. In addition to broad clinical interests in Orthopaedic Surgery, he has a special interest in sports medicine and is in charge of this program at UNC-CH.

Lewis E. Williams has been appointed Instructor in Cardiothoracic Surgery. He received the B.S. degree from Fordham College and the M.D. degree from the New Jersey College of Medicine. After an internship at Bellevue Hospital Medical Center, he was a resident at the Tufts-New England Medical Center, where he was subsequently Chief Resident in Surgery, Chief Resident in Thoracic Surgery and Teaching Fellow in Surgery. After two years in the military service he was named a Fellow of the Division of Cardiothoracic Surgery at UNC-CH in 1973.

Henry T. Frierson has been appointed to the faculty of the Office of Medical Studies. After his graduation from Wayne State University, he received the Ph.D. degree in Education Psychology from Michigan State University. While at Michigan State he was a Fellow in the Office of Medical Education, Research and Development. He holds an appointment as Assistant Professor of Family Medicine.

Robert D. Stone has joined the faculty of the Office of Medical Studies. His undergraduate degree is from Denison University, followed by an M.A. and Ph.D. from Michigan State University in Educational Psychology. During the past year he served as instructional consultant to the College of Osteopathic Medicine at Michigan State and to the Department of Surgery in the College of Human Medicine at that university. He was previously an Instructor at the University of South Florida. Dr. Stone holds an appointment as Assistant Professor in the Department of Family Medicine.



Danielson Leaving

John M. Danielson, General Director of The North Carolina Memorial Hospital, has accepted a position with an eight-hospital consortium in Hartford, Conn. The consortium, the Capitol Area Health Consortium, is the largest of its kind in the United States. Danielson said the member hospitals have determined their primary goals as "the monitoring of the quality of patient care provided by its members and to prescribe the standards of patient care desired."

Danielson joined the UNC faculty two years ago, after he had been Director of the Department of Health Services and Teaching Hospitals of the Association of American Medical Colleges in Washington, D.C.

Danielson said that he leaves behind him a staff of top-level

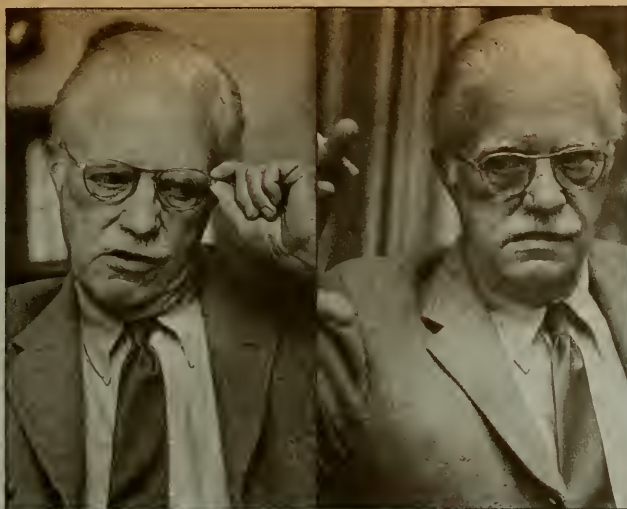
administrators, all of whom will continue to implement the hospital's five-year master plan. Through this plan, four of the 10 top-level staff members are directors of patient care offices in the hospital. Danielson said that this unique administrative arrangement had strengthened the quality of patient care in the hospital.

He gave credit to the dean, departmental chairman and the medical faculty — all of whom comprise the medical staff of NCMH — who he said had assumed "responsibility for professional management of the hospital and the cost of medical care."

His resignation was effective October 25, 1974.

A number of faculty donors have established the Leonard A. Palumbo Memorial Fund in memory of the late Dr. Leonard A. Palumbo, who was Professor of Obstetrics and Gynecology at the School of Medicine until his death in April. The fund will be used for as yet unspecified educational purposes. Your contributions are welcome and may be sent to:

The Leonard A. Palumbo Memorial Fund
c/o Mr. Etheridge H. Price
Dept. of Obstetrics and Gynecology
4019 Old Clinic
UNC School of Medicine
Chapel Hill, North Carolina 27514



Dr. George Ham

Honored by Hundreds

by Charles R. Vernon, M.D.

George Ham was honored in Chapel Hill by former faculty and housestaff members on September 13 and 14. Large numbers of his students, old and young, honored him with a dinner and a scientific session.

Douglas Bond, a renowned medical educator from Case Western Reserve and longtime colleague of George's, spoke historically of the revolutions he and George had experienced in their world before,

during and after World War II. These included the biochemical ones exemplified by the curative and preventive advances in use of antibiotics and vaccines; the genetic breakthrough with the discovery of the genetic code; the sexual revolution; and the revolutionary changes attending the women's liberation movement. There was, of course, a nostalgic quality to this warm and gentleman's presentation. Both the

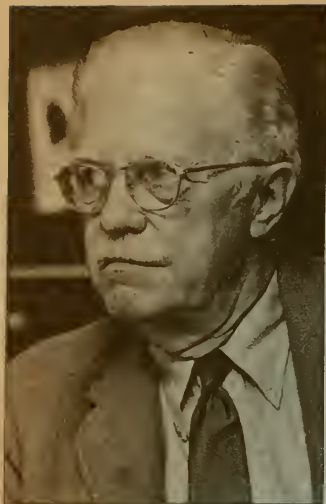
pain and the gain of progress was made evident in what he said and how he said it. He cautioned that advance or progress does not mean arrival. For example, some progressives would close all mental hospitals before, indeed, we have developed alternatives to hospitalization.

George responded to his friend's comments and the audience's ovation with impressive emotion. The group then flocked to Earl Somers' place for cocktails and conviviality. A banquet followed with proper words of remembrance from David Hawkins in person and from John Ewing and Morris Lipton by tape recording. Harvey Smith orchestrated with wry humor the after dinner presentations.

Saturday's scientific session did George the best honor. He could not help but be proud, and he said so! Wilfred Abse and Harley Shands co-chaired the meeting in their inimitable ways.

David Allen, first chief resident in George's Department, spoke about hysteria. He said hysterical conversion phenomena are still with us, adding that hysterics are great teachers of psychodynamics and that there are right and wrong ways to deal with their problems psychotherapeutically. Particularly, he warned, you had better watch transference and countertransference or you will be in trouble!

Bill McKinney, of NIMH, spoke of the Rhesus monkey as a handy non-human model for the study of psychopathology. Identifying with his mentor George Ham, Bill runs a psychiatric residency training program for Rhesus monkeys. Monkey therapists are



quite effective and seem to cure their patients in 2-3 months.

Peter Whybrow, chairman of Dartmouth's Department of Psychiatry, proclaimed psychiatry as the last bastion of ignorance in medicine. He enjoined the audience to be critical with him on what indeed is meant by the term "medical model." Peter says the dichotomy, being in or out of the medical model, is a pejorative one. It offers a spurious polemic with little, if any, real validity.

The history of this model in medicine is dominated by the advances of the last part of the 19th century. Koch's "putulates" and the one-disease-one-cause concept emerged then and continues to prevail. The splitting of scientific from the socio-cultural definitions of disease results in this artificial dichotomy. People, not scientists, define sickness, and in our culture people say both the caring (humanistic) and knowing (scientific) elements are important in the medical model. So the helper or healer must care about people as well as

know about people.

Bryce Templeton is at the University of Pittsburg, where he is distinguishing himself as a medical educator. Bryce acknowledges his "delusion" that evaluation has a commanding influence on the education process. Many educators of medical leaders don't or won't believe this, but Bryce maintains his "fixed idea" nonetheless. With this in mind, he believes we had better evaluate something that is really important in what we as physicians are supposed to do (validity) and that our evaluations should really accurately do just that (reliability). Bryce described potentially testable evaluation techniques for psychiatric training. Diagnostic and treatment skills in psychiatry are indeed difficult to evaluate, for the clear definition of a psychiatrist is not yet well enough delineated for evaluation.

George provided a last word of gratitude and hope, thus ending a delightful and educational occasion for many good friends, who dispersed to go back home (some after the ball game) wiser and warmer with a re-affirmation of meaningful connection to our department and its founder.

Much thanks must go to the Tom Curtis and the local folks in planning and hosting this occasion.

Who's where

20's

Verne H. Blackwelder, '27, has been elected Councilor of the North Carolina Medical Society from the Ninth District.

Donald P. Ross, '25, has moved from Niagara Falls to Youngstown, New York. His address is 343 Main Street. The zip is 14301.

30's

George C. Allen, '33, is practicing ENT in Lumberton. He writes that the article on Dr. Billy MacNider in the summer issue of the Bulletin "brought back fond memories. He was one of my favorite people."

Chalmers R. Carr, '33, is Speaker of the North Carolina Medical Society for 1974-75.

Jesse Caldwell, Jr., '39, was elected Councilor from the Seventh District for the coming year.

40's

Frank R. Reynolds, '43, has been elected President of the North Carolina Medical Society for 1974-75. A classmate of his,

Albert Stewart, Jr., will serve as Councilor for the Fifth District.

Other officers and councilors from the 40's are: **James E.**

Davis, '42, President-Elect; **Jack Hughes**, '41, First Vice-President; and **Edward G. Bond**, '46, Councilor for the First District.

G. Denman Hammond,

Director of the cancer center at the University of California School of Medicine in Los Angeles, has been appointed to the National Cancer Advisory Board of the National Cancer Institute. A member of the class of '46, he received the Alumni Distinguished Service Award this year.

50's

William R. Bullock, '58, is now practicing in Yukon, Oklahoma. His address is Route 2, Box 193A, zip code 73099.

James C. Parke, Jr., '54, is coordinating a trial immunization program for testing a vaccine for a form of spinal meningitis that is sometimes fatal to infants. The program is being conducted at Charlotte Memorial Hospital, where he is Associate Chairman of the Department of Pediatrics. Dr. Parke's project, which he has been working on since 1968, is funded by the National Institutes of Health.

Robert A. Farmer, '56, who is now a Colonel in the Air Force, has been stationed overseas since May. His address is General Delivery, 4 MSES, APO New York 09332. He was previously in Colorado Springs, Colorado.

60's

Howard D. Homesley, '67, is currently on the staff at David Grant Medical Center, Travis Air Force Base, California. He will return to North Carolina in July of next year, when he will become the director of the gynecologic oncology service at Bowman Gray School of Medicine.

John L. Currie, '67, has entered private practice in Chapel Hill. His office is located in the Connor Drive Professional Building.

Al Roper, '67, writes, "Carol and I are starting our third (and perhaps last) year here in Charleston, S.C. I am now Chief of ENT, Naval Regional Medical Center, 29408. Carol is president of Medical-Dental wives club. Plans

are for private practice in Norfolk in '75." He adds that he enjoys hearing from his classmates and is always ready for a visit from all who "find their way down here."

Fred McConnell, '68, finished his residency in otolaryngology at Northwestern University in June and received the masters degree in medical science. He is now stationed at Wright-Patterson Air Force Base in Dayton, Ohio, where he will be for the next two years. The zip code there is 45433.

Bruce A. Phillips, Jr., '67, spent two years at Womack Army Hospital, Fort Bragg, after completing his internship and residency at the University of Kentucky Medical Center. He has been in private practice in Elizabethtown since July of 1973. He and his wife Nancy have four adopted children - - Michael, Lara, Matthew and Mark. Their address: P.O. Box 86, Elizabethtown, North Carolina 28337.

Joel Rothermel, '67, is in orthopaedic practice in New York City. He also has teaching responsibilities at Columbia. His address: 55 Central Park West, 10023.

Bob Sevier, '66, is practicing internal medicine and endocrinology in Greensboro. He was Chief Resident in Medicine at The North Carolina Memorial Hospital last year. The Seviers live at 1118 Briarcliff Road. Zip code 27408.

Gerald W. Blake, '67, is now on the full time teaching faculty at Wake Memorial in Raleigh. He is working with **Evin**

Sides, '65, who is director of the medical service.

Erich Schweistrits III, '68, is in the Gastroenterology Unit at Walter Reed Army Hospital in Washington.

Robert C. Gibson, '66, is now practicing in Portland, Oregon. He moved there from Massachusetts in July. His address: 6645 Southwest Raleigh Lane, zip code 97225.

W. Bryan Latham, '63, is now in West Palm Beach, Florida. Until last June he was at the Homestead Medical Center in Homestead, Florida. His West Palm Beach address is 808 North Olive Avenue. The zip is 33401.

George Avant, '67, has moved from Nashville, Tennessee to 19 Chatelaine Drive, Greenville, South Carolina 29607.

Joe Swanton, '60, is now at the River Park Medical Center in McMinnville, Tennessee.

Hugh J. Grant, Jr., '69, is practicing Ob-Gyn in Raleigh. After he graduated, he spent a year in internship training in Augusta, Georgia. His office address: 100 South Boylan Avenue, Raleigh, North Carolina 27603.

Gerald Pelletier, Jr., '63, moved from Dallas, Texas, to New Bern this summer. He is now practicing orthopaedic surgery at the New Bern Medical Art Center, Suite 7, 800 Hospital Drive, New Bern 28560.

Oscar Bolch, Jr., '62, began practicing in San Diego this fall. He had previously been in Pasadena. His new address: 10990 Red Cedar Drive, San Diego, California 92131.

Zeb Little, '67, is a surgeon in Jacksonville, Florida.

He is located at 7041 Mount Vernon Circle, zip 32210.

James M. Rhyne, '68, is now in Statesville. He receives mail at 303 St. Andrews Road, Zip is 28677.

Parke Davis II, '66, is a surgeon with the Carolina Clinic in Philadelphia. The clinic address is 1700 South Tarboro Street.

Frederick Austin III, '67, is now in the Department of Medicine at the University of Louisville Health Sciences Center. Before moving to Louisville in July, he was in Quincy, Massachusetts.

At the end of July, **Terry Golden, '68**, left Fort Knox for Atlanta. He is now at 75 Brandon Ridge Drive, zip code 30328.

Peter L. Morris, '66, is practicing in Santa Barbara, California. His address there is 194 Olive Mill Lane, zip 93108.

Fred Avis, '69, has been appointed an Instructor in the Departments of Surgery and Bacteriology and Immunology. After completing an internship and two years of surgical residency at NCMH, he was named a Clinical Cancer Fellow for two years. He was also a Visiting Fellow in the Department of Pathology at the University of Washington in 1972. He is presently conducting an active investigative program in cancer immunology.

John Hugh Bryan, '69, is now an Assistant Professor in the Department of Pediatrics. After his graduation he completed internship and one year of a pediatrics residency at NCMH. Then he went to the National Cancer Institute, where he was a Clinical Associate in the Medi-

cal Oncology Branch for two years. He returned to Chapel Hill in 1973 as a Fellow in Pediatric Hematology and Oncology.

70's

Thomas R. Dempsey, '73, is in Gainesville, Florida, in a residency program at the University of Florida. He is living at 4132 Northwest 32nd Street, zip 32605.

Elizabeth Parker, '70, is in Philadelphia. Her address is Apt. B1115, Park Drive Manor Apartments, Lincoln Drive and Harvey Street, Philadelphia 19144.

James Sloan, '70, is practicing ophthalmology with his brother in Wilmington. He

is living at 1915 Glen Meade Road, zip 28401.

Ed Little, '71, who is in the Army, has been stationed at Fort Bragg since June. His address is 607 Shortridge Road, Fayetteville 28303.

Mike Yarborough, '72, left Parkland Memorial Hospital in Dallas in June. He is now living at 4301 Lake Washington Boulevard, N.E., Apt. 1207, Kirkland, Washington 98033.

Colin Jones, '73, who is now in the Department of Family Medicine and Practice at the University of Wisconsin at Madison, writes, "Greetings from the cold Northlands. It has been pleasant here. I liked skiing



and skating, but spring did take a while to arrive." His address is 1325 North Wingra Drive, Madison 53715.

Stan Rule, '73, is living at 2647 Southbury Circle in Birmingham, Alabama 35216.

W. A. Lambeth, '71, has moved to Newport News, Virginia. He's at 548F Turnberry Boulevard, zip 23602.

Marcus B. Simpson, Jr., '72, is in the Department of Laboratory Medicine at Johns Hopkins Hospital.

Dan Summerlin, '73, has completed his internship at the University of Connecticut and is now in a residency there. He writes, "For the most part I have been very pleased with the program even though the new Health Center in Farmington is not yet operational as they had assured me it would be. My family and I are enjoying our stay in Connecticut but the Chapel Hill and North Carolina area and people remain unsurpassed." The Summerlins live at 27 West Point Terrace in Tariffville, zip 06081.

After graduation, **James S. Henning**, '71, spent a year at Cleveland Metropolitan General Hospital, where he did a medical internship. He has just completed two years with the National Health Service Corps and is a Clinical Associate in the Department of Family Health Sciences at Duke. He has also been named a Robert Wood Johnson Foundation Clinical Scholar and is studying at the University of California School of Medicine in San Francisco. California address is 10 Marin Avenue, Sausalito 94965.

Philip May, '70, is a first year resident in internal medicine at the University Hospitals of Cleveland. He is living at 3532 Normandy Road in Shaker Heights 44120.

Lindian Joseph Swaim, Jr., '73, and Mary Kay Scott were married on June 23. She is the daughter of Mrs. Franklin Woodrow Scott and the late Mr. Scott. The couple is living in Durham, where he is an Ob-Gyn resident at Duke.

James O. Goodwin, '70, moved from Portsmouth, Virginia, to Orange Park, Florida, this summer. He is at 5519 Forrest Drive, zip code 32073.

Michael Gooden, '73, is now an Ob-Gyn residency at New Hanover Hospital in Wilmington. He lives at 1502 Cameron Court. The zip code is 28401.

Jerry Bernstein, '70, is a pediatrician in Raleigh. His office address is 3200 Old Wake Forest Road, zip 27609.

Doug Tilt, '73, is in Birmingham, Alabama. His address: 2607 Southbury Circle, Birmingham, 35216.

Frank Cashwell, '72, is on the staff at Duke, but he's still living in Chapel Hill—at 1905 Ephesus Church Road.

Larry W. Boyles and E. Joseph Walton, Jr., both of the class of '70, have been named Instructors in the Department of Medicine. Larry has just completed a year as Chief Resident in Neurology at NCMH and Clinical Instructor in Neurology. Before returning to Chapel Hill for his residency in 1971, he was an intern at the Medical College of Virginia. Joseph was an intern and resident at Vanderbilt before being named a Fellow of the National Heart and Lung Institute two years ago.

After completing her internship at the University of Virginia Hospital in Charlottesville, **Jane M. Foy**, '71, spent the first year of her pediatric residency at Eggleston Children's Hospital in Atlanta. She spent the second year of her residency at Moses Cone Memorial Hospital in Greensboro, where she is now an instructor in ambulatory pediatrics for UNC.

Duncan McRae, '72, and Pamela Edith Dudley of Cary were married September 19 in Dallas, Texas. She is the daughter of Mr. and Mrs. C.H. Dudley of Cary. They will live in Dallas, where Duncan is a resident at Parkland Hospital.

Donald Robert Rollins, '73, is now a resident in medicine at Bexor County Hospital in San Antonio. His home address is 4814 Allegheny, zip 78229.

What Kind of Doctor Do You Want Anyway?

What do you do here?" strangers in white coats often ask about my job. "Humanities," I say. A look of surprise and disbelief covers their faces. Colleagues in the humanities are equally puzzled and often skeptical. A president of a small college who was trained in religious studies, replied, "That's important, but how can you do it?"

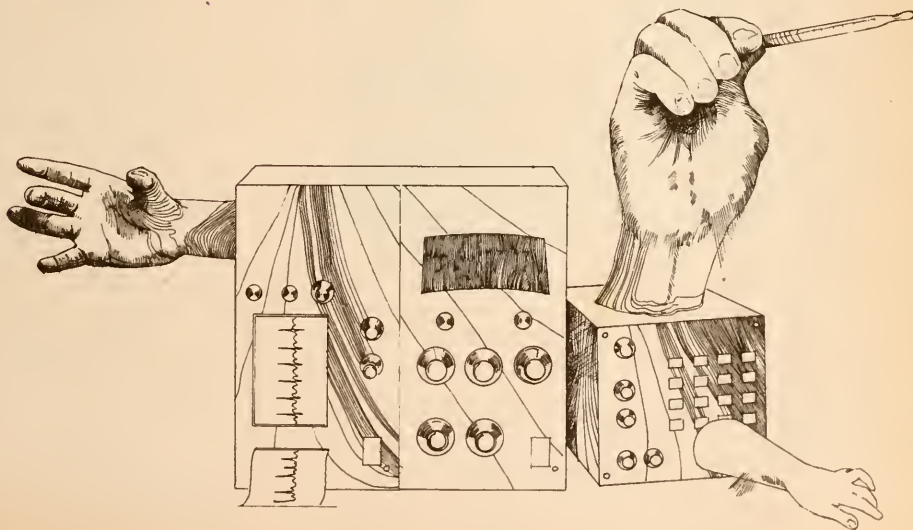
Such a view of the humanities — which sees it as alien to the methods and concern of medicine — is commonplace. Indeed, the dominant intellectual motifs for the last three hundred years in the Western world have claimed the division of knowledge into "science and humanities," "hard data and soft," "fact

and value." These bifurcations have held such a superordinate power over our ways of thinking and perceiving that the humanist in a medical setting is very much a stranger, and the methods and concerns he brings are as if from another culture. In short, the humanist in a medical school finds himself working against some of our most cherished and deep-seated assumptions.

Yet some of the most eloquent statements which legitimate broadening of scope and a deepening of purpose in medical

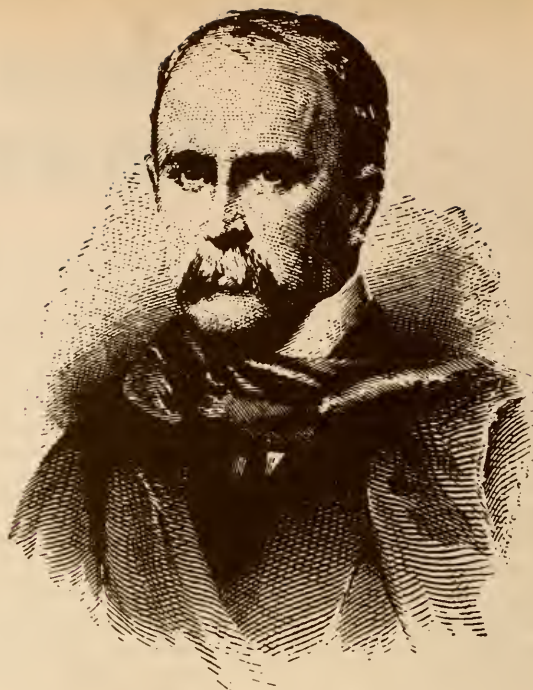
education have come from physicians themselves. Sir William Osler asserted that professional education of any sort tends to narrow the mind and limit the point of view. The length, stress and depth of commitment exacted from medical students during their training makes this narrowing of focus a professional liability even more pronounced in medicine than in other fields. And if the ability to think through a problem in all its dimensions was problematic when Osler spoke in 1903, it is far more problematic today.

Related to, yet distinct from, the liabilities of specialized training is the increasing reliance of medicine upon technology. Though it has become a cliché to



say so, it has not yet been fully fathomed that much of the interchange between medical professionals and their patients is mediated technologically. The recent literature concerning new criteria for, and new definitions of death witnesses to the peculiar modern inability to distinguish the patient from his sophisticated technological environment. Such mechanical intervention, important as it is, obviates the traditional grounds for patient trust in the physician and blurs the clarity with which physicians can perceive and treat persons as persons, not simply as containers of "disease entities" or "interesting cases". Increasingly, the routines of medical training place the student-physician at a remove from the locus of care and enhance his understanding of himself in terms of a polished, technical competence. "Regardless of what you may believe," one attending told his students, "you are just well-paid technicians." The increasing lack of trust for the judgments of physicians relates primarily, I believe, to this awareness that the physician moves in a world where the language of personal hopes and fears, of human values, has a diminishing power to be heard.

In spite of the spectacular success of scientifically-based medicine, many of the problems which physicians are called upon to treat do not admit to technical, scientific solutions. Pain, suffering, depression, alienation, chronic disease, disability, death and grief are non-technical-solution problems — problems of the human condition. They call



William Osler

less for the mastery of quantifiable factors in formal knowledge than for depth of insight, affective acuity and communication skills, namely, the sort of expertise which is traditionally associated with the humanities.

Arguments about the place of the humanities in a medical curriculum frequently pose false antinomies. "What kind of doctor do you want, anyway?", implying that one must choose between an ignorant sentimentalist and a compassionless professional. Again, the false assumption, deeply written into our culture, is that technical expertise and humane values are incompatible.

More frequently the argument is couched in terms of time constraints — ethical questions are interesting, but the curriculum is already overburdened with courses. Yet sociological studies show that medical students do indeed learn basic value orientations in the process of becoming professionals.

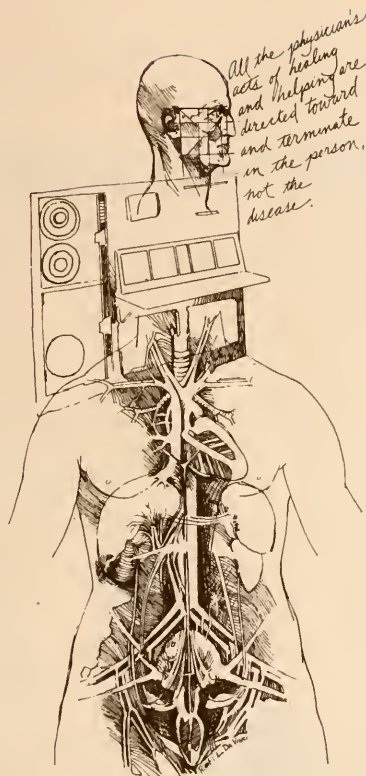
To deny their presence, or their importance, leaves this value transmission unexamined and mostly to chance.

It might prove convenient if medicine could be taught and practiced in a moral vacuum, but the interaction between doctor and patient makes this innocence

possible. The practice of medicine is inherently moral; it did not suddenly become so with the prevalence of abortion or the advent of organ transplantation. Medicine is a morally-laden endeavor because it involves one human being with another, usually in a relation characterized by a great privilege of access to the patient's body and personal history.

Though it would be a serious mistake to think of a humanist in medical education as a moral expert or ethics consultant, one assumption of the enterprise is that the perspectives of the humanities are relevant for medicine, and even foundational to it. Human value considerations, while not easily quantifiable, are data, which in the plexuses of clinical medicine have an impact upon the disease and health experiences of individuals, families and communities. Many of these value facets are so embedded into the routines of training and practice that they go unrecognized, constituting part of accepted procedures and customs. The humanist's task, among others, is to bring these tacit value dimensions to light and to encourage students and faculty to consider them critically. By such critical reflection upon their training and their emergent roles, student-physicians could gain a perspective from which to make judgments that are consistent with human values and humane commitments.

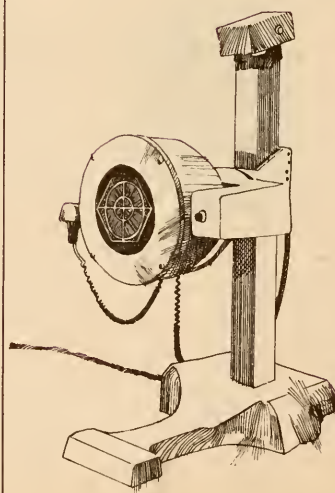
It would be a fundamental mistake to suppose that the humanities are humanizing, or that ethically sound decisions will necessarily follow from a



humanities program. No such correlations exist. Yet the methods peculiar to the humanities can broaden and deepen the present truncated emphasis which results from an exclusive reliance upon the natural sciences as purveyors of medical realities. A focus not opposed to science, but larger and more personal is called for — one which can integrate what we know scientifically into an existential frame of reference. Our present reliance upon the sciences as the basis of modern medicine is not debilitating, but our obsession with the impersonal purity of such knowledge makes it intransitive. A framework which recognizes the value-laden character of all knowledge should not only enhance the treatment of patients; it should also enable the physician to deal with situations which are stressful and potentially disintegrating.

The primordial task of a humanities emphasis in medical education is to raise the question of values and to support an inquiry which draws attention to the ways professional patterns of training place values upon some things to the exclusion of others. The purpose of such an emphasis is not to supply student-physicians with even more material to master, for the knowledge acquired from the inquiry I suggest is neither instrumental nor systematic. Rather the purpose is to educe from the student-physician an awareness of and a commitment to his or her reflective sensibility in the context of one's own bodily presence and in relation to the issues of humanness in one's professional activities. Too often our thinking about ourselves and

our work proceeds exclusively under the aegis of the "systems analysis" approach in which the object of knowledge — conceived as distinct from its environment — is reduced to its simplest components, analyzed and reconstructed in numerical fashion. The typical medical school catalogue reflects precisely this kind of understanding. Consider the implications which are packed into courses entitled "cell histology", or "gross anatomy," and the variety of offerings on the systems — cardiovascular, respiratory, endocrine, etc. Such an approach to medical knowledge, essential as it may be, gives credence and informal legitimacy to a kind of thinking in which human bodies are no more than the aggregate of bodily systems, functions and components. Though great accomplishments have characterized the educational programs structured on this Baconian-Cartesian model of knowledge, I believe the monopoly this disembodies mode of thinking currently enjoys in medicine effects an unrootedness of the professional from the human condition. It is one of the characteristics of modern educational practice that professional training is almost exclusively confined to the mastery of methods and materials, acquisition of "tools" which "equip" the professional for his job. Even those teaching endeavors which seem to raise value questions are often couched in the language of systems analysis and formalized knowledge. But the acquisition of skills such as affective neutrality and patient empathy are not



susceptible to measurement as "behavioral objectives", and to so treat them is only to diminish their value by reducing them to the single vision of a fully objectified medical experience. This tendency to disembody and package even the most personal and tacit of medical skills is additional witness to the pre-emptive power of analytical modes of thinking — nothing can be known, or trusted, unless it can be measured. The experience of alienation and the absurd is the psychic price many medical students pay for scientific "enlightenment" and technological prowess. "We begin our training with an instinctive knowledge of the therapeutic power of our persons," says one recent graduate, "but many of us leave thinking that if we were stripped of our technical apparatus we would be useless."

The presence of a humanities program in a medical school is no panacea, but it may be a move toward integrating the bits and pieces of medical data into a clinical knowledge which enlivens the ability of physicians to see and accredit what is at stake in human terms, both in themselves and in those for whom they care.

All the physician's acts of healing and helping are directed toward and terminate in the person, not the disease. The justification of a humanities program in medical education is grounded in the vision of patients-as-persons and in the realization that the physician's most potent therapeutic instrument is still himself.

UNC Medical Alumni Bulletin
226 MacNider
Chapel Hill, N.C. 27514

Alumni can save us hours of research time by supplying the following information to:
Medical Alumni Records
226 MacNider Hall
Chapel Hill, N.C. 27514

MAILING NAME

Preferred format, if different from label

UNION CLASS

Preferred class affiliation, if different from label

ADDRESSES

Professional:

Residence:

Other:

Please check preferred mailing address and include ZIP code.

Statistical Data

Specialty

Sub-Specialty

Professional Activity: ☐ Active Practice

☐ Retired

☐ Graduate Training

☐ Leave of Absence

☐ Career Military Service

☐ Never Practiced

☐ Temporary Military Service

☐ Other

Residence at Entrance to UNC School of Medicine:

North Carolina County

Out of State

Personal Data for Medical Alumni Records

Familiar Name: If your classmates did not use your first given name, please indicate your "called name" &/or "nickname"

Medical Alumni Siblings: Please give full name and class of those who became physicians.

Medical Alumni Parents: If he or she attended this medical school at any time, please give full name and class.

Father:

Mother:

Other:

Indicate step-parent, in-law.

Parents Club (for post-1956 alumni) So that we can update our medical parents mailing list, please give name and address of your living parents.

UNC Medical Alumni Bulletin
226 MacNider
Chapel Hill, N.C. 27514
Return Requested

Non-Profit Organization
U. S. POSTAGE
PAID
CHAPEL HILL, N.C.
PERMIT NO. 24